CULTURAL VIEW OF NURSING IN SAUDI ARABIA

Abstract

Background: **Modern nursing in Saudi Arabia is a complex issue in which cultural diversity presents the major challenge to the evolution of Saudi nursing as an independent indigenous professional workforce. Historically, patients and the nurses in Saudi Arabia come from different linguistic and cultural backgrounds with the reliance on a predominantly foreign nursing workforce, resulting in culturally based conflicts.**

Aim: **This report opens a window into Saudi Arabian nursing practice in action for international readers, through which the complexities of the problems from a Saudi standpoint are presented.**

Discussion: **Literature shows misunderstandings and conflicts with patients through the lack of cultural skills in how to interact with them in a culturally appropriate manner which can give rise to conflicts and tensions. These can endanger patient care and increase the risk of errors, the consequences of which could prove fatal.**

Recommendation: **Care should be taken during the processes of recruitment and orientating foreign nurses practising in Saudi Arabia. Cultural sensitivity of the nursing cultural requirements needs to be enhanced by the development of educational protocols for cultural competency for all nurses.**

Conclusion: **The distinctiveness of the culture of the Saudi Arabians and the control by foreigners with scant knowledge about their culture, heightens the challenges of providing nursing care that is culturally proficient. Nurses should understand and acknowledge variations that define patients from different cultural settings. If nurses have a good grasp of the cultural attributes of their clients, then they are well placed in caring for them.**

Key words: **culture, nursing practice, Saudi Arabia, diversity**

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Introduction

Contemporary healthcare is undergoing many changes and challenges that include social, technological, consumer demands and increasingly complex bioethical dilemmas. Such environments demand that nurses be educationally prepared to meet the needs of people from different backgrounds to deliver optimum quality of care (1). Diversity within particular work places is no exception. Clients and patients most likely act, as well as think differently compared to their nurses. In Saudi Arabia (SA), a culture influenced by Islam, there are particular challenges because the nursing workforce is predominantly foreign (2).

There are significant dimensions of culture that impact on nursing practices in SA. Understanding these facets of culture during the delivery of nursing services may aid nurses in establishing and growing stronger linkages with their patients, as well as de-escalating possible conflicts attributable to cultural differences. Such culture-related misunderstandings at times colour how Saudi Arabian patients relate with foreign nurses, especially those from the West. If nurses have a good grasp of the cultural attributes of their clients, then they are well placed incaring for them (Aldossary et al. 2008, Almalki et al. 2001 Eliasson et al. 2008). (3-5)

This discursive paper explores the history of nursing in Saudi Arabia and examines dimensions of culture in the society and its effects on nursing practice in health care facilities.

Culture in Saudi and its impact on Healthcare

Saudi Arabia is a young country which was unified in 1932. Since then, the population has rapidly increased and so have the demands for health care, and in particular the roles for professional nurses (6). Like many other disciplines in Saudi Arabia, the health care sector has undergone many changes due to social, technological, governmental, economical changes, and customer-related demands. These rapid changes have direct effects on the nature of health care delivery, such as hospitals and the healthcare environment. As is known, the healthcare environment is complex since it gathers many different groups under an intricate organisational structure. Saudi Arabian hospitals in particular are extremely complex, being reliant on a dominant international nursing workforce. These complexities, along with increasing demands and shortfalls in staffing, can create grounds for conflict among health care professionals (7). Similar to the Saudi health care structure, El-Amouri and Neill (8) assert that the United Arab of Emirates (UAE) is a highly multicultural community consisting of 25% Emirates and 75% expatriates. Such diverse contexts hold risks for many delivering health care, especially for nurses who communicate and interact with patients from different linguistic and cultural backgrounds. Staff are expected to know the meaning and practice of diverse culture, and practise in a culturally sensitive way.

Cultural Values

Leininger (9) describes cultural care as being holistic and respectful of differences and similarities of values, beliefs and lifestyles. Additionally, culturally competent nursing care is "sensitive" to matters of culture, race, gender, sexual orientation, economics and social class. Pickrell (10) stated that "cultural shock is a common phenomenon and occurs when nurses care for patients from cultures different from their own" (p. 130). These issues, if left unresolved, may leave nurses exposed to the risk of making errors, either minor or serious. Westerners and Arabs share many values such as having strong family relationships, the importance of children and the goal of having a peaceful life. However, in health care, due to differences in culture, background and traditions, many conflicts may emerge.

Lack of cultural awareness, lack of communication and language barriers have major impacts on the delivery of hospital-based health care. El-Amouri and Neill (8) discussed examples of ways that cultural sensitivity may alter the care-giving process. A health care worker may make an error in examination due to limited physical contact because of cultural and language barriers, which may affect the quality of care. For example, some cultures alter the care planning process; a patient may not understand the complications of either discontinuing medication, or having an early discharge just because they are feeling better, or refuse admission for cultural reasons. For example, in SA as a Muslim community, aside from medical intervention, suffering is considered a test from God "Allah" and one's task is to endure it and not lose faith. In Western communities, on the other hand, this matter is faced with further discussion and other options, such as euthanasia, may be considered (11). Other reasons affecting health care delivery have been connected to healthcare workers' cultural insensitivity, patients' social status, patients' inability to afford health care, and unavailability of services compatible with diverse groups (8). Underutilisation of health care services by different cultural groups have been identified across the globe; for instance, for African Americans, people of colour in Canada, refugees in Australia, and indigenous people.

Gender

In the Middle East, gender segregation is socially allowed, sanctioned, and actualized through varied structures of governments. In open or public spaces such as hospitals and their wards, for instance, different genders cannot intermingle. In such spaces there are varied physical environments that are zoned out for females, families, and males. Women, including female nurses, cannot work alongside or interact with male nurses in a majority of settings, except when it is absolutely essential (12-14).

Commonly, women are allowed into careers such as teaching, social work, banking, nursing, and in developing and building the capacity of other females. However, in SA they cannot drive or ride alone and hence, are wholly dependent on males for their transportation requirements. Males are charged with offsetting their family fiscal requirements even where their spouses are employed. This is so except when mutual decisions are made concerning alternatives to allow for concession. However, females are permitted to set up and manage their own enterprises, invest any resources they have and possess property (3-5).

Like most places in the world, the majority of nurses in Saudi Arabia are female, perhaps more evident because of the segregated systems of education. These systems allow only for limited female and male socialization, and subsequently a number of Saudi nurses elect not to offer care to sick males. Largely, patients are cared for by nurses of their gender (3-5). However, where there are significant shortfalls of nurses, nurses from both genders might be assigned to care for patients of either gender. The involvement of female nurses in nursing practice is thus limited, as the nature of the job will always necessarily be mixed-gender (12-14).

Family Approval and Support

In Saudi Arabian society, families are central. Families are of an extended nature, with each individual being part of a family that includes cousins, parents, siblings, grandparents, uncles, and other relatives. Families are considered the framework of the identity of individuals. Saudi culture seeks to preserve and strengthen family linkages by paying visits, celebrating others' attainments, supporting and having compassion for them and respecting all. In urban environs, relatives often reside close to one another, promoting family socialization (3-5). This means that nurses can amply engage family members in offering care to their relatives. Grandparents as well as parents are highly respected and wield significant authority when it comes to their offspring's health and healthcare. This authority impacts on how nursing services are provided. In the case of elderly patients, they expect to be treated in a similar manner to how they are treated at home. They expect nurses to be humble, patient, gentle and softly spoken towards them. Family members expect that the nurses who offer services to their family members be appropriately and conservatively dressed, to be reserved as opposed to being outgoing and wary of making uncomfortable disclosures which may injure the honour of the patient (7, 15-18).

In Saudi society, tarnishing an individual's honour is equated with tarnishing the honour of her or his entire family. This phenomenon is widely applied in other Arabian and neighbouring communities. Aspects that are closely linked to dishonour include mistreating the elderly or the weak, meanness and sexually-related immorality and indecency. Discussions relating to the demise and/or ill health of Arabs are unavoidably focused on families. The needs-based affiliations of Arabs intensify when their relatives are ailing (12-14). Patients are often accompanied by several relatives whose expectations include being present when the diagnosis or related interviews take place. Relatives listen keenly and commonly respond on behalf of the patient and the elderly may feel slighted by nurses who fail to usher them into the offices of physicians (19-21).

Elders suppose it is their duty to accompany their close relatives in all the phases of their ill health as a sign that they care for them. Families insist, or demand, that patients get the best nursing care and demanding characteristics are cultural prescriptions that show the care that a family holds regarding their sick members (3-5). Expectedly, families demonstrate remarkable concern by always offering company to the sick and continually showing them care and attention. Most Arabs need to be affiliated to, celebrated and appreciated by their families and they appreciate immense repertoires of family ties and relations in satisfying their affiliation-related needs (19-21). During crises or sickness, Arabs substantially rely on relational ties, as opposed to coping in other ways. Patients who do not receive adequate family support through frequent and sustained visits in the course of their illness, are commonly lonely and may feel rejected and isolated from their relatives. The involvement of caring friends along with family is linked to doubts and mistrust regarding other people's intentions, including nurses (3)(4, 5).

Others, including nurses, are viewed by patients as being outsiders in relation to their close circle of friends and family members. Many challenges that colour the relationships of nurses and patients in Saudi Arabia gradually dissolve if nurses are allowed membership in family systems. This approval allows nurses to combine authority and expertise with individual warmth as they attend to patients. Such a combination engenders more trust, compared to purely professional approaches (3-5). Most Saudis grow trust in a nurse if she or he demonstrates competence when caring for their relative. Trust also increases if families get personally, and not professionally, acquainted with a given nurse. Nurses find it helpful to offer individual information to families for purposes of increasing their trust in them and their practice. A nurse should readily respond to families' questions, even personal ones. Withholding a response might prompt families to withhold essential health-related information (3-5).

Nursing Education in Saudi Arabia

Nursing education was initiated in 1958 in Riyadh, the capital city, with fifteen Saudi males enrolled in a one-year nursing program (3). A few years later similar programs were offered for women in Riyadh and Jeddah. By 1981, admission criteria for nursing courses had risen from fifth and sixth grade to ninth grade entry level as the program curriculum had expanded into a three-year program. The Bachelor of Science in Nursing (BSN) was introduced to Saudi Arabia in the late 1970s, followed by the establishment of masters programs in 1987 (22, 23). All early BSN programs were exclusively for females. The first male BSN program was reported in 2006 with 307 students enrolled in a four-year academic program in Riyadh (2). With Saudi hospitals built on Western models, health care facilities and related educational institutions are becoming more westernised. It has become clear that one of the issues facing nursing education in the Arabian region is recognising how cultural bias is embedded in textbooks used within the courses. Even though textbooks reflect the importance of cultural diversity as a value, those available strongly reflect Western culture (11).

As opposed to other professions, such as teaching, which are stringently segregated on the basis of gender, nursing entails working closely with patients, doctors and individuals of the opposite gender. This has added to speculations among families that nursing should not be welcomed as an occupation with pronounced tendencies of directing their members towards more professionally and socially celebrated careers such as medicine, albeit still involving contact with the other gender. Female nurses are seen as being markedly vulnerable to risking

their own reputation, as well as jeopardizing the social standing of their family (24). However, nursing roles for women have historical Islamic roots. From the eighth century during the early ages of the prophet Mohammad, women were a part of the Muslim army body as nurses to treat the wounded in tents. Rufaidah Bint Sa'ad Al-Ansareyah is recognised as the first Muslim professional nurse, who later had established the first nursing school to teach volunteering women nursing skills and how to care for the ill (25).

Although nursing education in Saudi Arabia, and in the Middle East in general, has gone through major developments, it is still a profession with societal and cultural stigmas (23). Another source of conflict is that in SA female nurses must have their applications for employment approved by their male custodians, the "mahrams". Such approval processes place females at the mahrams' mercy. At times, the mahrams have been reported to react violently if nurses work night shifts, render care services to males, or attend to weekend assignments in the workplace (3-5).

Like Saudi Arabia, Qatar is a tribal society and cultural norms and social status have been noted as having a major impact on the education process (11). For example, these factors may contribute to acute discomfort for individuals exchanging feedback, even if it includes constructive criticism, and it would be difficult to give negative comments to a person with a high social status. These cultural differences have significant implications for the models of nursing education.
In the United States of America, it is an essential requirement that baccalaureate nursing graduates have the knowledge and skill to care for diverse populations. This demands knowing and understanding the effects of culture, race, age, gender, religion, and lifestyles on health and methods of care delivery (1). It is critical to involve health care workers because they are at risk of experiencing cultural shock and consequent stress and conflict.

Conflict

Conflict within an organisation comes in four forms: interpersonal, which is created within the individual; intrapersonal, which occurs between two or more individuals; intergroup/ support, which occurs between two or more groups who are supportive at work while having differences in competing for power, resources, and status; and intergroup/ other departments, which occurs between two or more groups for resources and services and where the conflicts are centred around control and might be competitive (26). Conflict among nursing professionals has been seen to drain energy, cause discomfort and hostility and produce confusion (7).

Conflict caused by cultural insensitivity can take many forms. El-Amouri and Neill (8) highlight factors that hinder culturally competent care between patients and healthcare workers. These include lack of understanding of other cultures; stereotyping; lack of effective communication; nurses' own linguistic and diverse backgrounds; and the health care organisation's poor design to support culturally diverse patients. Generally, in the Middle East, nursing practice lacks professional regulation. Therefore, institutions tend to create their own policies on the roles of nurses and nursing practice, hence, hospitals may handle issues differently from one another (27).

Teamwork and Peers

Nursing assignments carried out by teams in SA often suffer from the social segregation of sexes. In SA, teams should comprise individuals of the same sex, as strict separations are maintained between genders. When engaging their peers at the workplace, nurses of Saudi extraction have been reported to respond to their minority statuses in varied ways (12-14). They may work harder so as to earn recognition comparable to those given to nurses from dominant racial backgrounds. At times, Saudi nurses prefer being away from the limelight and many seek to conceal their attainments. Foreign nurses often view their Saudi peers as irresponsible or spoilt, as they often place requests to be assigned to daytime shifts, flexible arrangements for working, and frequent leave to handle family commitments (3-5).

Multicultural Workplace

As noted earlier, globally, there is a shortage of nurses. In some countries the shortage has been occasioned by the desire of nurses to seek jobs abroad, where they are sure of better working conditions and compensation. The movement of nurses from one cultural setting to another affords them multicultural experiences (24). However, such experiences can colour the lives of nurses in Saudi Arabia where most nurses are from Western cultural backgrounds. Nurses working there can be confronted with a variety of problems relating to customs, healthcare-related practices, language, and communication (12-14).

In SA, a nursing career is not considered as desirable as other professions. Poor perceptions about nursing in the region, gender-related restrictions, and a sustained population expansion have heightened the dependence on foreign nurses. In 2011, more than two thirds of the nurses offering services in the country were expatriate (2). Foreign nurses bring with them unique cultural persuasions and ideals. The Saudi authorities source the greatest number of nurses from the United Kingdom, Malaysia, South Africa, Australia, the United States of America as well as immediate neighbouring nations (2). For these nurses, it is almost always certain that varied cultural backgrounds are represented. The professional, social and cultural backgrounds of expatriates are markedly dissimilar to those of native nurses, each other and of their clients. A number of studies have shown

that foreign nurses within the country are confronted by challenges in appreciating and satisfying their clients' cultural needs. They are advised on the helpfulness of employing consulting negotiators of culture in resolving the challenges in offering services to the native patients (3-5).

Variously, negotiators or translators in the work place need not have nursing experience or training. Rather, they should embody wide-ranging experiences of living within the Saudi populace, or have the requisite bi-cultural experiences. These negotiators serve as brokers of cultures, linking distinct subcultures or cultures. They interpret variations in style of communication, languages and preferences of values as well as lifestyles. As interpreters they significantly help in the enhancement of nursing services delivery. While Saudis have remarkable needs related to affiliation, Westerners value individualism and are not as strongly tied to families and networks of relatives (24).

Other aspects and experiences that define multicultural environs, especially in the context of Saudi populations and foreign nurses, relate to appreciation of time, contexts and spaces. The frequency and intensity of their relationships make their culture markedly contextual. They seek to develop meaning out of events by evaluating the circumstances surrounding them in their entirety (12-14). Westerners find Saudis desirous of knowing more regarding a person than a Westerner does, for purposes of establishing relationships. Unlike Saudis, Western nurses place a low value on context; rather, focusing more on the particular happening, message, act, or relation (14).

In terms of time, expatriates find the Saudis less concerned about punctuality (28-31). Patients may come late for a care service or fail to come altogether if other commitments crop up. Westerners generally get annoyed by people who approach time casually, while Saudis may be annoyed by the Westerners' tendency to talk of all essential matters at the earliest possible chance, without developing relationships as a prelude (21). Expatriates may feel that Saudis are invading their personal space when conversing with them, as most Saudis prefer to stand about two feet away from the person with whom they are conversing. This ensures that they can thoroughly discern the other's reactions as the conversation goes along. Westerners prefer a longer conversation gap of around five feet. Saudis also touch others more frequently than Westerners (24).

Saudis, though generally welcoming open communication as well as truth, are averse to communicating openly during crises, severe illnesses, disasters and when there is a looming death. The Saudis' denial, when faced with those matters, is in direct conflict with the Westerners' desire for entire disclosure regarding any information that is regarded fateful (3-5). In Saudi Arabia, denial presents an ethical challenge to all healthcare practitioners, including nurses. Saudis, being Muslim, hold the belief that given the extent to which a diagnosis is severe, mortals should not lose their hope, as a loss of hope means that they have forfeited God's aid. Hope aids patients in coping with and managing ill health, even where such hope is deemed futile, especially in the Western region of the country (21).

Confronting ailing individuals with serious diagnoses is seen as tactless and unforgivable in Saudi Arabia. Patients' relatives serve as their clearinghouses regarding information on diagnoses. Families often intervene, sometimes violently, to ensure that the information is blocked (24). Such interventions are recognized in other countries, such as Jordan and the United Arab Emirates, and do not attract feelings of guilt on the part of concerned families, because they feel justified that they have blocked potential harm that could have been inflicted on their family members (6, 32, 33). Indeed, it is thought that ailing individuals who become privy to their state of malignancy may lose all hope. Commonly, nurses and other healthcare experts communicate serious prognoses tactfully through nonverbal ways. They doggedly regress from verbally uttering fatal findings to patients along with their families (21).

Culture and Competency in Nursing Practice

In the modern world, diversity within workstations is not an exception. Clients and patients most likely act as well as think differently compared to their nurses. They embody wide-ranging cultural identification, material actualities, religions, behaviours, and beliefs that enrich cultural diversity and complexity. Every patient and every nurse is exceptional. The nurse should be competent, in relation to a patient's culture so as to efficiently take care of her or his cultural and other necessities (34, 35). Cultural competence denotes a collection of attitudes, policies, and behaviours that, together, enable nurses and others to work efficiently within transcultural settings.

Such competence incorporates and acknowledges cultural essences and evaluation of cross-cultural relations. It acknowledges the significance of awareness regarding cultural variation dynamics, growth of cultural knowhow, and modelling of services for purposes of meeting special cultural necessities (27, 36-38). Nurses ought to understand and acknowledge the variations that define patients from different cultural settings. Each patient, regardless of the setting, should be offered valuable and compassionate care. In Saudi Arabia, studies have shown that foreign nurses are somewhat devoid of knowledge regarding their cultural considerations and practices relating to the nursing

profession such as, breastfeeding, evil eye, medicine, Ko'hl (a cosmetic similar to an eye liner), food-related taboos, and modesty (24).

These matters can be addressed during the processes of recruitment and orientating foreign nurses practising in Saudi Arabia. This may improve the standard, or quality, of the care they offer Saudi patients. Nurses need to improve their understanding of other cultural matters such as use of herbal extracts by females (12-14). They should have a polished understanding of diseases particular to Saudis, such as their cultural sensitivities relating to caring for expectant mothers as well as children, the males' health-related roles concerning their families, and how placentas are disposed of. In developing culture-related competencies, nurses should examine their own specific cultural persuasions, beliefs about healthcare, prejudices and biases and their origins (34, 35).

To gain knowledge of the culture of clients, nurses can review published literature or attend relevant seminars. The competencies that they attain should include skills relating to the gathering of cultural information about conditions of patients. Nurses should heighten their involvement and engagement in cross-cultural interactions. Additionally, foreign nurses should be devoted to becoming culturally knowledgeable about the Saudis and their patients in particular (3-5).

Conclusion

The distinctiveness of the culture of Saudi Arabians and the control by foreigners with scant knowledge about their culture, heightens the challenges of providing nursing care that is culturally proficient. This paper has discussed the history of nursing in Saudi Arabia and examined the dimensions of culture in the society and how these affect nursing practice in health care facilities.

Nurses need to understand and acknowledge the variations that define patients from different cultural settings. If nurses have a good grasp of the cultural attributes of their clients, then they are well placed in appropriately caring for them.

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