



## **A PHENOMENOLOGICAL STUDY OF NON-MUSLIM NURSES EXPERIENCES OF CARING FOR MUSLIM PATIENTS IN SAUDI ARABIA**

**D. Alosaimi**

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

**S. Dyson**

*Middlesex University, Faculty of Nursing, Middlesex University, United Kingdom*

**D. Anthony**

*DeMonfort University, Health and Life Sciences, Leicester United Kingdom*

The purpose of this study was to explore the experiences of non-Muslim nurses caring for Muslim patients in Saudi Arabia. The study sought to understand from the perspective of non-Muslim nurses what it is like to care for Muslim patients in a religiously and culturally conservative society. The study is positioned within a framework of theories about transcultural nursing care and is primarily concerned with the role of religion in the nurse-patient relationship. A qualitative approach was used adopting hermeneutic phenomenology to understand the nurses' experiences. Non-Muslim nurses from various countries took part in focus groups and both nurses and Muslim patients took part in interviews. The study has found that religious, cultural and linguistic factors have a negative effect on non-Muslim nurses' experience of caring in Saudi Arabia which includes a personal impact and a practical impact on working practices.

**Keywords:** Saudi Arabia, Muslim patients, Non-Muslim nurses.

### **Introduction**

In an increasingly globalised world there are more interactions between nurses and patients of different religious and cultural backgrounds. Views about health and disease vary between cultures and this has created a healthcare sphere that is characterised by different cultures and different cultural ideas about caring for patients. Therefore, the need for training and education about transcultural care in nursing has become more important. Although transcultural training is now very much part of curricula in institutions, provisions to teach culturally sensitive care and the approach to education, research and practice in this area has been inadequate (Narayanasamy, 2003).

In Saudi Arabia religion plays a significant role in the non-Muslim nurses' experience of care because the country, in comparison to other Muslim countries, is religiously conservative and religion plays a role in every aspect of Saudis' lives, particularly when it comes to health.

Patients' behaviour and attitudes will be largely influenced by religion, thus it is conceivable that patients will have concerns about non-Muslim nurses, who are largely responsible for care.

For Muslims illness is very much part of their destiny and has been ordained by God, and during illness a Muslim will depend on God to help them and will increase their supplication to God. Therefore, Muslim patients during illness are dependent, conscious and fearing of God which leads to an increased piety, and this makes them more concerned about being cared for by someone who does not understand or is even concerned about religion issues.

This study examines the experience of non-Muslim nurses caring for Muslim patients in the context of Saudi Arabia. The study examines the challenges the nurses and patients have and expose any deficiencies in nursing training. The experience of Muslim patients being cared for by non-Muslim nurses is also examined to highlight the relationship between religion and culture. Although the main focus of the study is religion, it also considers wider cultural factors.

### **Study Area**

Saudi Arabia as a modern state was established in 1932 by Abd Al Aziz bin Abd al-Rahman Al Saud (Ibn Saud). The Kingdom adheres to Sunni Islam and has endeavoured to pursue inter-faith dialogue, supported by an initiative in December 2005 by King Abdullah; the idea has been to promote religious tolerance.

There are a large number of expatriate workers in Saudi Arabia and many of them are not Muslim. Their presence in the Kingdom has no impact on the societal and ethical behaviour of locals because there is no interaction between expatriate non-Muslims and Saudi Muslims outside of the working relationship (Vidyasagar and Rea, 2004). One of the settings of importance in relation to this phenomenon is in healthcare situations, as clearly the normal societal patterns are not displayed with the result that Muslim patients who would not normally interact with non-Muslim individuals are forced to do so, due to circumstances of 'ill health'.

The King Faisal Speciality Hospital and Research Centre (KFSH&RC) was established in 1970 and currently specialises in tertiary care and only on a referral basis. Moreover, the hospital has the latest medical equipment and performs advanced procedures such as open-heart surgery and kidney transplants and is also the main referral hospital for cancer treatment and also receives requests from overseas for treatment at the hospital (Mufti, 2000).

The hospital currently has 936 beds and 18 medical departments. There is a total of 6,946 staff from which there is representation from 63 different nationalities. There are 703 medical staff, of which 46 percent are expatriates including 16 percent from the United States and Canada and 11 percent from Europe. On average, 32,000 patients are referred to the hospital each year (KFSH&RC, 2012).

There are a total of 1,942 nurses, 18 percent of whom are from Canada and 11 percent from the United States. The remainder are from the UK, Europe, New Zealand, Australia, the Philippines and Saudi Arabia (KFSH&RC, 2012). Therefore it is clear that the hospital represents a multi-cultural society, while the population of Saudi Arabia itself is predominantly homogenous and Muslim.

### **Healthcare in Saudi Arabia**

Healthcare in Saudi Arabia is considered a right and is provided to all Saudi citizens free of charge, a basic right entrenched in Saudi law. Most of the care, i.e. 75 percent, is publicly funded and 25 percent is from out-of-pocket expenditure. A distinctive characteristic is that the use of private medical insurance is very low (Walston et al., 2008).

There are two major factors that have an effect on health services in the Kingdom. Firstly there are many foreign workers, and secondly there is a very large young population. It has been suggested by Walston et al. (2008) that these demographics affect the future direction of the Saudi health service.

The development of healthcare in Saudi Arabia, much like other public services, has been closely linked to the economic success of the Kingdom, as the Kingdom of Saudi Arabia (KSA) is a major world oil exporter. Because of this there has been no economic restraint with the healthcare service being given a boost because of the ability to acquire the latest technology (Gallagher and Maureen Searle, 1985). This immense oil wealth has provided opportunities to educate Saudis and provide highly advanced technical medical services (Tamim et al., 2010).

### **Research Questions**

1. Is religion a significant factor in the care relationship between non-Muslim nurses and Muslim patients in Saudi Arabia?
2. What are the implications for the training of non-Muslim nurses caring for Muslims patients in Saudi Arabia?

### **Objectives**

1. To understand, from the perspective of non-Muslim nurses what it is like to care for Muslim patients in Saudi Arabia in terms of religion and culture.
2. To explore from the perspective of the Muslim patients what it is like being cared for by non-Muslim nurses in terms of religion and culture.

### **Research Design and Method**

This study employs a hermeneutic phenomenological approach to the research to reveal the experiences of non-Muslim nurses caring for Muslim patients in Saudi Arabia. This approach is based on philosophical hermeneutics proposed by Heidegger and aims to go beyond core concepts and address the situatedness of individuals in relation to the wider cultural, social and political contexts (Swanson and Wojnar, 2007).

### **Sampling**

Because the study adopted an interpretive phenomenological analysis (IPA) (Carty et al. 1998) only a small sample size was required. For those participating in the focus groups it was important that they were able to give the required information and should also represent the overall population under research. Although the participants were all non-Muslim nurses, they were varied in terms of the departments they worked in, their level of experience and their qualifications.

There were three focus groups, two groups of four and one group of three. All of the nurses hold positions in medicine, obstetrics, gynaecology and surgery. The nurses had at least one year experience, and possessed a diploma or Bachelor's degree in nursing. Interviews were held with eight nurses and eight patients. The nurses were divided equally according to level of education and experience as with the focus groups. Importantly, the nurses had to be non-Muslim.

### **Data Collection**

The study employed focus groups and semi-structured interviews for the nurses and semi-structured interviews for the patients. One of the main reasons for using focus groups was because of the power relationship between the researcher who is a Muslim, Saudi nursing lecturer and non-Muslim nurses where it was felt that this relationship may prevent the nurses from speaking freely which would not be suitable in phenomenological study which aims to describe phenomena in an uncontaminated way (Bradbury-Jones et al., 2009).

Semi-structured interviews were used in order to understand the experiences of the nurses. In relation to this idea Seidman (2006) says that interviews are not merely about getting answers to questions they are also about gaining an insight into the lived experience of the interviewees. Semi-structured interviews allow the researcher to structure an interview schedule which can be used in IPA to create a loose agenda of questioning (Smith et al., 2009). The nurses were encouraged to talk about their experiences of caring for Muslim patients with specific reference to religious issues in the care relationship.

### **Data Analysis**

The focus groups and interviews were recorded and transcribed. The derived data was qualitative and thus, was non-numeric and unstructured and therefore, it is necessary to use a system of coding in order to reveal emerging phenomenon (Basit, 2003). In consideration of the method of coding it was decided to reject computer software because for a smaller sample size it is more appropriate to use manual coding, moreover, it was difficult to justify using software because of the time and expense required (Basit, 2003), therefore, manual coding was used.

### **Ethical Considerations**

It was important to protect the nurses and patients from harm or risk and to adhere to ethical guidelines throughout the research. This included informed consent and making it clear to the nurses that should they wish to discontinue and/or withdraw from the study they were free to do so. Confidentiality was assured for all participants throughout the research process and dissemination of the findings. Individual nurses and patients remained anonymous and data was kept secure. Contact information was provided in full by the researcher.

### **Discussion**

For the nurses religion was a significant factor in the experience of caring for Muslim patients, affected their ability to provide care, and had an impact on them personally. The findings revealed that religion affected the nurses' ability to provide care and directly affected the nurses' workload and working routine.

#### **Religion as a Factor in the Experience of Caring for Muslim Patients**

The effect that religion had on the nurses' experience manifest in three ways. The first way was related to administering care; the nurses felt that religion impeded their ability to provide care; examples included not being able to remove patients' clothing, such as the Niqab (face

covering), and fasting and prayer interfering with care regimens. The second way was that religion disrupted the nurses' working routine; they had set schedules and had to carry out specific duties, however, issues related to religion made them busier and stop the nurses from managing their time. The third way was that the nurses were personally affected by religion because they had to conform to certain behaviours and felt they were not respected because they were not Muslim, for example, they were often asked to convert.

### **Ramadan and Fasting**

During Ramadan most of the nurses said that there was a significant impact on their working routines. This was because patients were awake during the night and asleep during the day and would only take medicine between sunset and sunrise. The nurses felt that this sudden change to the patients' routine was detrimental to their health. One of the nurses said the following:

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

A few the nurses had to find a quiet place to eat or drink, which also wasted time. Eating or drinking in front of Muslims during Ramadan in Saudi Arabia can lead to cancellation of the work visa (Toumi, 2012) so the nurses had to be careful. In a study by van Rooyen et al (2010) it was found that nurses had to hide water bottles in paper bags which lead to feelings of discrimination.

### **Prayer**

Muslim patients prayed five times a day, which had an effect on the nurses' working routine and scheduling. The nurses found that they had to continuously change their routine to accommodate prayers; the following statements express this idea:

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

And

Also, here there is a prayer time and you wanted to give some medication or some treatment to the patients or if they have an appointment, they would first ask to allow them to pray and then they will be prepared to go with you. So, once we are here for sometimes with patients, then we are aware that there are specific times when the patients will be praying and then we adjust our plan according to their times so that we do not bother the patients during prayer times (Nurse 3)

### **Covering and Modesty**

Most of the nurses were surprised by the fact that many of the female patients wore the face covering (niqab) in the hospital and that they had to work around the niqab, especially because the nurses themselves were female. Al Shahri (2002) says that in hospitals in Saudi Arabia even when a female nurse examines a female patient there are difficulties because the patient will shyly resist uncovering certain parts of the body. The nurses felt strongly about this issue and cited cases where women could have died as a result.

### **Defence of Professionalism**

Among most of the nurses, there was a strong sense that they had to defend their professionalism with respect to caring for Muslim patients in the sense that as professionals they could care for any patient regardless of the patient's religion. This professionalism or the defence of professionalism was a very important issue for the nurses. However, further investigation revealed that the nurses were not saying their professionalism means the ability to provide culturally congruent care to patients of any faith; rather they were saying that the religion of a patient is not a significant factor and that their professionalism as nurses was related to their ability to take care of anyone.

### **Culture**

All of the nurses experienced culture shock and they often contrasted their experiences with other Arab countries, portraying Saudi Arabia in a negative light. It was evident that the culture shock was related to how conservative and strict Saudi culture was. It should be remembered that religion has shaped culture in the country and there was confusion between what was cultural and what was religious. However, it was clear to the nurses that there were cultural reasons that caused a lack of respect for nurses; one example was that they were viewed as simply hired help. This was also found to be true by Brown and Busman (2003) who said that in Saudi Arabia nurses are not seen as the primary care provider, and because of cultural reasons they are not fully accepted because they were not Saudis.

The nurses expressed a contradiction between religion and culture. Religion controlled who the nurses could touch and who they could be alone with, the contradiction was that these were restrictions were imposed only for female patients which was a result of cultural practices, male patients did not mind using female nurses, although the Islamic rulings are the same for both genders. Al Shahri (2002) also made this observation, that Islamic religious rulings forbid unnecessary touching between the sexes, however, it was more applied to female patients not being cared for by males, which Al Shari (2002) attributed to culture.

Another aspect of Saudi culture noted by the nurses was that female patients do not have a voice regarding their medical procedures because male guardians have to give permission for their medical procedures. Similarly, Leever (2011) cited a case where a Middle Eastern woman left all medical decisions to her husband which frustrated the physician.

### **Being a Non-Muslim, Female, Expatriate Nurse Working in Saudi Arabia (Lack of Respect)**

The most significant way that religion and culture affected the nurses personally was that they were not respected because they were non-Muslim, female and expatriate nurses. This lack of respect manifest in different ways and came from different parties in the workplace. The lack of respect extended to the nurses feeling vulnerable and fearing false accusation for inappropriate behaviour.

The fact that the nurses of other faiths, or of no faith, was not respected. Nurses resented pressure from the patients or Muttawa (religious police) to convert to Islam and they took this as a disregard for their beliefs. It was a common feeling among the nurses that they were looked down upon because they were not Muslim.

The nurses also felt disrespected simply because they were female. Society in Saudi Arabia is male dominated and this is evident in the nurses' experiences. One example cited by a number

of the nurses was that their professional opinions were not respected by male doctors in contrast to their experience in other countries. The attitude of male doctors, staff and patients could be attributed to the fact that the nurses were working females because Saudi Arabia has a patriarchal male-dominated society where the male is the breadwinner (Elamin and Omair, 2010). Moreover, the literature has shown that the nursing profession is not held in high regard in Saudi Arabia due to cultural reasons, which is the reason for the high dependency on foreigners in nursing. In support of the idea of male dominance, Elamin and Omair (2010, p758) stated that Saudi males see themselves as 'dominant, independent, competitive and capable of leadership and women are submissive, dependent, caring and good for domestic tasks and child rearing'. In comparison to other Arab countries, the nurses felt that this attitude is more prominent in Saudi Arabia.

A prominent aspect of the nurses' experience that made them understand the position or status of an expatriate nurse was that in any dispute between the patient and the nurse, the hospital always sided with the patient; the nurses attributed this to the fact that they were not Saudi. This idea was supported by the fact that patients themselves pointed out to the nurses that they were Saudi when nurses complained to them about not following care regimens. One nurse cited an example where she was being treated like a 'slave' and called security to help her, who then sided with the patient.

### **Patients' Families**

A major feature of the nurses' experience attributed to culture that had an impact on care was the behaviour of the patients' families. The nurses were impeded in providing care because they had no control over the situation because the patients' families often interfered; this invoked a feeling of loss of control and uncertainty. The nurses noted a high level of involvement, influence and interference by patients' families, which impacted directly on care. Halligan (2006) noted the same problem where the role of the family played a significant part in the experiences of expatriate nurses in Saudi Arabia and that these families impeded care. Furthermore, van Rooyen et al. (2010) found that expatriate nurses in Saudi Arabia found it difficult to perform their duties because of interference from patients' families and Sidumo et al. (2010) said that 70 percent of non-Muslim nurses found family involvement in the care of the patient to be a significant challenge.

A specific example of how patient families interfere was that they controlled the information given to the patient, especially if it was bad news. This agrees with Halligan (2006, p 1568) who says that families in Saudi Arabia often 'dictated the care' without the patient's knowledge, and that this was a cause of stress for nurses. According to Al Shahri (2002) in Saudi culture it is the family who decides how much information is given to the patient.

Therefore, this study agrees with other writers; Al Shahri (2002) said that a patient's autonomy is overruled by the family who also often influence medical decisions. Van Rooyen et al. (2010) said that expatriate nurses in Saudi Arabia were impeded by patient families who determined when nurses carried out their duties, and Walczyk (2006) comments on the fact that the extended family, specifically older males, have influence over care decisions. These opinions were held by the nurses in this study that the patient's family has too much influence and also interferes with care.

### **Fear of False Accusation**

The nurses feared false accusation for inappropriate behaviour because of the culture in the country, and they had to be mindful of how they interacted with male patients. This issue was

particularly a problem because the nurses depended on non-verbal communication, which includes eye contact and smiling, unfortunately, these are frowned upon between male and female in Saudi Arabia. Similarly, Bola et al. (2003) says that patients who have limited cultural understanding may interpret nonverbal forms communication as inattentive, disrespectful or subservient; however, in this study the concern was that such misinterpretation would lead to the nurses being accused of being flirtatious.

### **Language**

Language was found to be an impediment to care; however, the nurses did understand the importance of learning Arabic and showed the initiative to learn the language. Unfortunately, the nurses were let down by the hospital because they did not provide adequate language training in that it was too general and not tailored to nursing care. This led to a language barrier and the nurses were forced to depend on translators, colleagues and patients' families, which negatively impacted on care.

Not being able to speak Arabic meant that nurses found patient compliance to be difficult because they could not explain the benefits of following care advice. Priestley (2000) describes her experience as a staff nurse in Saudi Arabia and says that the greatest frustration was the inability to communicate with patients which complicated simple tasks. According to Easterby et al. (2011) this inability causes frustration in nurses and patients and can lead to miscommunication about health status and medicine.

The inability to communicate extended to communication with the patients' families, which was a problem because of the aforementioned influence that they have and that they would control or misinterpret information given to patients. The nurse's workload was increased because they had to spend more time to explain care issues to people other than the patient.

The language barrier also wasted time in discerning patients' needs because the nurses had to look for translators who were not always available. Priestley (2000) says that using interpreters is timely even when relaying basic information. In fact, translators were generally a problem for the nurses. Aboul Enein and Ahmed (2006) said the use of an ad hoc translators could lead to inaccurate information and also breach patient confidentiality. Priestly (2000) describes this issue as a 'bubbling cauldron of potential error in communication.'

### **Providing Culturally Congruent Care and Training and Development**

The study revealed that the nurses lacked an understanding of transcultural care and where they did have understanding, it was not sufficient or appropriate for a country in which religion dominates all aspects of life.

However, it would not be fair to blame the nurses themselves for not being fully educated in transcultural care, they had made every effort to learn about Saudi culture before arriving in the country and blamed the problem on lack of training and orientation related to providing culturally congruent care in Saudi Arabia. The nurses did acknowledge that they were entering a country that was religiously conservative and they made an effort to learn from their colleagues. In relation to this idea, Purnell (2005) says that nurses progress from being unconsciously incompetent to being consciously incompetent, that when a nurse is unconsciously incompetent they are not aware that they lack the required knowledge of another culture, and when they become consciously incompetent they become aware that they lack this knowledge.



A majority of the nurses said that the hospital is partly to blame for insufficient training because it neglected that it is necessary for nurses to have Islamic and Saudi-specific knowledge. Indeed, evidence from this study shows that most of the problems faced by nurses could be addressed by appropriate training tailored specifically for the Saudi context.

When the nurses discussed religion as an aspect of the experience of caring for Muslim patients, they focussed on religious practices, such as ablution and fasting, and there was little acknowledgement by the nurses of the spiritual needs of the patients. The only consideration in this regard is when nurses said 'Bismillah' (In the name of God) when administering medicine, which the patients were comfortable with. There was very little evidence that the nurses were proactive in providing for spiritual needs. In fact, some of the Saudi patients said they would prefer Saudi nurses because of this reason. It has been suggested by Ross (1997) that, because a person's health will depend on spiritual wellbeing, then nurses should not disregard spiritual care.

In reference to the practical religious needs, although the nurses did accommodate religious practices, the patients were not entirely satisfied with how nurses met their practical needs. An example of this dissatisfaction was ablution where some of the patients said that the non-Muslim nurses did not perform it properly.

## Conclusion

Non-Muslim nurses caring for Muslim patients in Saudi Arabia face unique challenges that are presented in a country that is religiously conservative. The study shows how religion permeates every aspect of a Muslim patient's care and how this impacts on the Non-Muslim nurses' ability to provide care.

In addition to religious factors, the nurses also had to face cultural and linguistic problems which were not adequately addressed by the hospital through training and education.

The study reveals that there is a clear need for Saudi Arabia to address these issues especially for the sake of the patients, there is a real need to manage the nurses in all aspects of working in Saudi hospitals. In order to make the nurses more culturally congruent it is also necessary to respect their values and their professionalism as nurses.

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