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The Perceptions and Experiences of Nursing in Saudi Arabia

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Fahad Abdullah Alhetheli

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List of Abbreviations

ANA	American Nurses Association
ANC	Australian Nursing Council
BS	Burnout Syndrome
BSN	Bachelor of Science in Nursing
ER	emergency room
GDHA	General Directorate of Health Affairs
HI	health institutes
ICU	intensive care unit
KSA	Kingdom of Saudi Arabia
MOH	Ministry of Health
MOHE	Ministry of Higher Education
MUHREC	Monash University Human Research Ethics Committee
NCS	National Competency Standards
NHS	National Health Service
PBUH	peace be upon him
PBUT	peace be upon them
PHCC	Primary Health Care Centre
SCERH	Standing Committee on Ethics in Research Involving Humans
SNC	Saudi Nursing Council
UK	United Kingdom
UN	United Nations
WHO	World Health Organization

Abstract

Little is known about the issues faced by Saudi nurses in Saudi Arabia. In Saudi Arabia, only 20 per cent of nurses are Saudi citizens. Nursing is able to attract but not retain nurses and the level of education is not meeting world standards. The impact on the population is that foreigners who do not understand the Saudi culture are providing care, which, although technically adequate, is not able to meet all needs. Adding to the problem is the fact that nurses have little control over their practice or education and are currently powerless to make changes.

Until now, there has been minimal research exploring the experience of being a Saudi nurse. To address this gap, this research has begun to uncover the experiences of Saudi Nurses and explore their needs, based on their perceptions of themselves and their understanding of their development and practice as professional nurses.

Using a Husserlian philosophy and following the framework of van Manen (1990), a hermeneutic phenomenological approach was applied. A semi-structured interview was used to collect data from 17 Saudi nurses who each had at least five years' nursing experience. These nurses were from the Eastern, Northern, Central and Western regions and included five male and 12 female nurses.

The participants' experiences highlighted that Saudi nurses have many significant problems. Two major classifications emerged from the participant's perceptions: sociocultural factors and organisational paradoxes. Sociocultural factors relate to external pressures that Saudi nurses face, while organisational paradoxes relate to problems regarding the internal structure of nursing organisations. The participants' perceptions of themselves as nurses included not only views about

education, nursing practice and the management of nursing organisations, but also involved their views on the behaviour of society towards the nursing profession.

Findings from this research reveal a sociocultural paradigm that still culturally segregates being a nurse from being a Muslim. In general, social support and organisational commitment is lacking in nursing. The commitment of nursing organisations towards nursing education, practice and management is perceived by the nurses interviewed as not reflecting the cultural values and principles of Islam, because the intentional aspect of Islamic law is ignored. This affects the working conditions of nurses and the status of being a nurse. As a result, Saudi nurses, instead of experiencing nursing as a rewarding career characterised by the caring ideals of Islam, are unsatisfied in their profession.

The perceived needs of Saudi nurses are extensive and their lived experiences reveal disempowerment and neglect. The result is that Saudi nurses are leaving their profession at a time when Saudisation is pushing for a greater percentage of Saudi citizens in nursing.

The findings of this study, and an examination of related research, point to strategies and recommendations to facilitate the development of nursing practice, management and education in Saudi Arabia, so that the perceived critical condition of Saudi nursing can be turned around.

In the Name of Allah, the Most Beneficent, the Most Merciful.

Prologue: Being a Saudi Nurse—a Personal Perspective

'Nursing is associated with menial work requiring little intelligence

or education. As such it is considered below the dignity of most

Saudis and better left to foreigners' (El-Sanabary, 1993, p. 1337).

Nursing is a noble career. However, as evidenced by the above comment,

nursing has not been accepted in Saudi society as a worthwhile profession. We have

a desire and a need for change and we have the right to be heard. Saudi nursing is

crying out for many issues to be addressed. These issues include improving the

knowledge and skills of nurses, the impact of society's views on nursing and the lack

of appropriate nursing administration. However, to date, the voices of nurses in

Saudi Arabia remain silenced.

My journey as a nurse started as a patient. Before I was a patient, like many

Saudi people, I was not aware of nurses or nursing. As a patient, I watched the work

of nurses with admiration: they *cared* for me and I became well. On reflection, this

was a turning point in my life and I eventually decided, in spite of family concerns,

to become a nurse, not knowing at that time where this journey would lead me. I

began by enrolling in a Diploma of Nursing, which was taught in Arabic, thinking I

was learning to be a nurse.

I will explain this comment. In Saudi, the language of the hospital is English.

Consequently, the language of tuition—Arabic—was at odds with the language I

was expected to use in the hospital. We did learn basic nursing care and skills.

However, upon entering the hospital as a student, I experienced difficulty

communicating with foreign nurses[1] because they all spoke English. Our clinical

learning experiences were not supervised by qualified nurses, and those nurses who

were in charge appeared to have no interest in assisting the students. The patients did

not trust us—especially me. They were suspicious of a man working in a

predominantly female profession. As a result, the gaps that formed in my learning

and development severely hindered my ability to function as a nurse. I graduated and

started working as an assistant nurse. My English was limited to 'yes' and 'no' at

this time and I was not effective as a nurse.

In addition, there was a significant difference in what I had been taught, and

the knowledge that I actually required. This confused me. My Diploma of Nursing

course was supposed to make me equivalent to a licenced nurse in America.

However, when I went to America for an intensive English course, I discovered it

was not equivalent. The gaps in what I should know and what I did know soon

became evident. Nevertheless, I still saw nursing as a worthwhile occupation to

pursue and knew that nursing was respected in other societies.

I was fortunate. A Filipino nurse became my mentor and I started to learn

what it was really like to be a nurse. I enrolled in an Associate Degree course at a

health college that was taught in English. Upon graduation, I became a Unit Charge

nurse. Gradually I became more and more competent and by 1999, I was a nursing

supervisor. At this stage, I thought I was practicing at a satisfactory level.

I worked as a Saudi nurse for 15 years. In 2003, I was given the opportunity

to study in Australia, starting with a degree in Nursing. On reflection, I knew very

little at this time. This became evident throughout the degree, especially as I had the

opportunity to do supervised practice in Australian hospitals. My study continued

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[1] 80 per cent of nurses are from overseas (MOH, 2007).

with a Master's degree. At the end of this degree, I realised I still had major gaps in my nursing knowledge and understanding.

I started to feel troubled about nursing in Saudi Arabia. I questioned the standard of my experience of Saudi education, the level of knowledge that had been taught to me, my level of skill development and the opportunities I had been given for clinical practice prior to graduation. Underlying these issues was the attitude of the Saudi public towards nursing.

One day, when working in Saudi Arabia, I was challenged by a religious man. 'Don't you think that you are in a situation which is prohibited in Islam?' he said. 'What is wrong?' I replied. 'You are the only man working with women. This is not appropriate for a Muslim. Working alongside women will affect the income you earn, so you better find someplace else to work, where men and women are not working together.'

As will be discussed further in a later chapter, it is common for Saudis to believe it is socially and religiously wrong (*haram*) for male Saudis to work with women: that it is not in keeping with the teachings of the Holy Qur'an. I realised this gentle man who spoke to me was speaking from a religious viewpoint, but unfortunately, his argument relies upon an understanding that does not recognise the importance and appropriateness of a Muslim being a nurse.

To some it seems there is a single identity for a Muslim. This belief ignores the significant other identities a Muslim person has, like being a nurse or working in a nursing environment. Claims that make nursing difficult for Saudis, such as that men and women should not work together, affect nursing culture, as well as affecting Saudi nursing administration. I believe these attitudes have a major impact on most Saudi nurses whether they are male or female. It all amounts to Saudi nurses being criticised just because they are Muslims and their fellow Muslims have different

expectations of them. As long as people claim that men and women cannot work together in the nursing profession in Saudi Arabia, the negative attitude and impact on Saudi nursing will continue.

There have been ongoing debates about the roles of men and women in Saudi society as well as in nursing. Islamic scholars in Saudi Arabia teach that men cannot work with women in the same place. They also teach that women cannot work together with men in their domain. There are no verses in the Holy Qur'an that say this, yet it is accepted as Islamic teaching. Islamic scholars promote this view and Saudi society accepts it. This is a significant factor influencing Muslim males' preference for male nurses, and there is no doubt female Saudis prefer women to look after them.

All the health care facilities in Saudi Arabia, including in the private sector, have been established with separate units for men and women. There is no need for 'mixing', in which men and women work together. There is no need for nurses to work with patients of the opposite gender. Mixing rarely happens. So, what is the problem with being a nurse? Further, if I and other nurses listen to the advice of men like the one who criticised me, who is going to take care of the Saudi population? In fact, expatriate nurses are taking on most of the responsibility of nursing. However, questions have been raised about whether they can provide appropriate care for the Saudi people.

It is my contention that for the nursing profession in Saudi to attract and retain Saudi staff, changes must occur in education, practice and organisational structure. However, for these changes to be effective, the voice of native nurses must be heard. Their experience is critical if we are to start to understand where change must occur.

Chapter 1: Introduction

Nursing has been a part of civilisation since the beginning of time; it is mentioned in the three recognised Holy Books: the Torah, the Bible and the Qur'an. Nursing is practiced in a social context and within the laws of the land. In most Western countries, nursing has developed in parallel to society's needs.

Many aspects of Western countries, such as education, industry and medicine, became organised early in their social history. At the turn of the twentieth century, the area now known as Saudi Arabia was a collection of mainly Bedouin tribes. At this time, there was no formal education system. Each tribe looked after its own, as there was no organised health system and industry was non-existent (other than trade in raw materials).

This chapter will provide a social context for this research, as it affects the research question. A brief history of the Kingdom of Saudi Arabia will be provided and an overview of the Islamic religion and culture of Saudi Arabia will be summarised in some detail concerning how it relates to this research. This chapter will describe the rationale behind the research, identify the research aim and potential significance of this research and outline the structure of this thesis.

1.1 The Kingdom of Saudi Arabia

Saudi Arabia is an Islamic nation, in which religion determines custom and law. The Kingdom of Saudi Arabia (KSA) was established in 1932 by King Abdul-Aziz Al-Saud (Mufti, 2000). Saudi Arabia is an Islamic absolute monarchy, which is governed by ministerial rule. The constitution is based on the Holy Qur'an and Shari'ah Law. All laws and regulations are delineated then proposed to a commission of Ulama, or religious scholars, to ensure that they are in accordance

with the Islamic Shari'ah. The executive and legislative branches of the Saudi Government are represented by the King (known as the Custodian of the Two Holy Mosques), the Council of Ministers and the Consultative Council (Majlis Al-Shura) (Majlis Al-Shura, 2009, 2011).

King Abdul-Aziz called for the application of Shura (consultation) soon after he arrived in Mecca in 1924 (Majlis Al-Shura, 2009). King Abdul-Aziz made Shura the foundation of his government to fulfil the divine order by applying Shari'ah and Shura as parts of it. King Abdul-Aziz intended to establish an Islamic Shura state applying Shari'ah as it is prescribed in the Qur'an and authentic Sunnah[2] (Majlis Al-Shura, 2009).

The Majlis Al-Shura remains the foundation of government policy, as anyone can formally make a request to Saudi leaders, the King, governors or any other prominent leaders in government. This policy is intended to ensure the government's objective of maintaining and safeguarding Islamic traditions and the teachings of Islam. Members of the Majlis Al-Shura must be of good character, well-educated and Saudi nationals by origin and birth (Majlis Al-Shura, 2009; Mufti, 2002, p. 2).

On 1 August 2005, the Custodian of the Two Holy Mosques, Abdullah bin Abdul-Aziz, became the King of Saudi Arabia, and he continues to follow Islamic rule. The relevance of all this in relation to this thesis is that to understand Saudi Arabia and to understand the lived experiences of Saudi nurses, we must understand Saudi society, and all the cultural and religious influences upon it. As well as this, there needs to be an understanding of the country's development.

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[2] Deeds and teachings of Prophet Mohammed, peace be upon him (the second source of knowledge).

1.1.1 The Development of Saudi Arabia

The traditional, mainly Bedouin, kingdom began to develop rapidly with the discovery of oil in 1938. As the oil industry evolved, the country's socioeconomic situation developed enormously (Mufti, 2000). The discovery of oil launched Saudi Arabia on a path of rapid social and economic expansion (Gallagher & Searle, 1985). In 1974, a national census was conducted and the results published in 1977 estimated the Saudi population to be 6,939,642. However, in 1985, just 11 years later, the United Nations (UN) estimated the population of Saudi Arabia to be 11.6 million. This increase in population was primarily attributed to a high birth rate among Saudis (Gallagher & Searle, 1985; Mufti, 2000). According to Mufti (2000), there was also a rapid decline in the mortality rate because of the improving economic and health situation. The UN projections expected the Saudi population to have reached 20.8 million by the year 2000, and 44.8 million by 2025 (Mufti, 2000).

KSA has a relatively young population. The most recent census conducted by the Ministry of the Economy and Planning (MOEP) (2007) indicated a population of approximately 23.9 million. Saudis accounted for 72.9 per cent of the total population which was 50.4 per cent male and 49.6 per cent female. The non-Saudi (expatriate) component of the population was said to be 27.1 per cent. The number of Saudis below 30 years of age represented 72.6 per cent of the total Saudi population, and those below 15 years of age constituted 45.2 per cent. The annual population growth rate was estimated at 2.3 per cent (MOEP, 2007).

Source: SAIR, 2006a.

Figure 1.1. Map of Saudi Arabia.

The Kingdom itself (see Figure 1.1) occupies approximately 2,250,000 square kilometres. It is bordered on the north by Jordan, Iraq and Kuwait; on the east by the Persian Gulf, Bahrain, Qatar and the United Arab Emirates; on the south by the Sultanates of Oman and Yemen; and on the west by the Red Sea (SAIR, 2006b). The need for appropriately qualified Saudi nurses becomes evident given the actual and projected population growth. Other factors also support the need to develop the Saudi nursing profession and reduce the dependence on expatriates. These factors will be discussed later in this chapter.

1.2 Religion and Culture in Saudi Arabia

The religion and culture of Saudi Arabia is essentially derived from the Qur'an and the narrative of the prophet Mohammed (Peace Be Upon Him) (PBUH; ﷺ *sala Allahu alaihi wa sallam*),[3] and is the centre of the social structure of the Saudi people. The following section explores the foundation of the religion and

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[3] When mentioning in word or voice the prophets of God—that is, Abraham, Moses, Jesus and Mohammed—it is required to show reverence and respect by saying, 'Peace be upon Him/ Them' immediately afterwards. In this thesis, this will take the abbreviation of PBUH/T.

culture of Saudi Arabia to provide an understanding of the context in which nursing

exists. There are many misconceptions about Islam and Saudi culture because, in

many respects, Saudi Arabia is a closed country.

1.2.1 Islam

Islam is the name of the religion revealed to the prophet Mohammed (PBUH)

nearly 15 centuries ago. In Islam, the fundamental duty of each Muslim is to submit

to Allah (Arabic for God) and to give obedience to His law (whatever Allah wants of

them). The prophet Mohammed's (PBUH) mission was to complete God's message

given to Abraham, Moses and Jesus (PBUT) (Omar & Allen, 1996). Allah said:

> 'This is the Book (the Qur'an), whereof there is no doubt, a
>
> guidance to those who are Al-Muttaqun [the pious and righteous
>
> persons who fear Allah much (abstain from all kinds of sins and
>
> evil deeds which He has forbidden) and love Allah much (perform
>
> all kinds of good deeds which He has ordained)]' (Qur'an 2/2).[4]

The Qur'an is the last revealed word of God (Allah) to the Prophet

Mohammed (PBUH). Allah said, 'Verily, we have sent it down as an Arabic Qur'an

in order that you may understand' (Qur'an 12/3).[5] The Qur'an is the primary source

for all Muslim knowledge. Its essential theme is the relationship between Allah and

His people. The Qur'an contains the words of Allah as revealed to the prophet

Mohammed (PBUH) in Arabic through the Archangel Gabriel. It is thought that the

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[4] The Qur'an, (1989). Surah Al-Baqarah, (2/2). (Arabic version, Translated by Yusuf Ali) Saudi

Arabia: The Holy Qur'an Complex in Madinah.

[5] The Qur'an, (1989). Surah Yousuf, (12/3). (Arabic version, Translated by Yusuf Ali) Saudi Arabia:

The Holy Qur'an Complex in Madinah.

Qur'an was transcribed by the prophet's cousin, Ali, during the period of Mohammed's life (PBUH) and in the years following his death.

It is believed that the transcription is exactly as it was revealed to him and that it has maintained its legitimacy since its revelation (Omar & Allen, 1996). Sunnah or Hadith (the second source of knowledge) is a technical term used in the Shari'ah (Islamic law). It refers to the binding rules derived from the Prophet's sayings, or Hadith. The Sunnah then represents the laws that can be extracted from the Hadith, the second source from which the teachings of Islam are drawn. It represents the collection of the traditions of Mohammed (PBUH), including his sayings and actions, and his tacit approval of what was said or done in his presence (Kamali, 1991).

The goals of Islam are concerned with all aspects of being human, including knowledge, principles, worship, transactions and law. At the same time, they provide a strategy and detailed teachings for a just society, appropriate human conduct and a reasonable economic system. Muslims believe that this life is a journey towards a specified place (Heaven) and they know that there are two pathways, one safe and the other unsafe. To take the way to Paradise instead of the way to Hell, Islam imparts to its followers a sense of direction that remains present in their minds throughout their lives. The ultimate aim is to win admission into Heaven. Every action Muslims do can either bring them closer to that overall aim (*halal*) or move them away from it (*haraam*). Through the Prophet Mohammed, God said:

'O mankind! Verily, the Promise of Allah is true. So let not this

present life deceive you, and let not the chief deceiver (Satan)

deceive you about Allah' (Qur'an 35/5–6).[6]

Therefore, a faithful Muslim always considers their actions before

responding. If they are of strong faith, they have no hesitation in refraining from

doing anything that diminishes the likelihood of them being admitted into Heaven.

They are always aware that they may die at any moment and they know that they

must be prepared for the hereafter. Any pleasure found in anything forbidden moves

them away from attaining their goal. God wants people to be pious and righteous,

fearing Allah and abstaining from all kinds of sins and evil deeds that He has

forbidden. Through the Prophet Mohammed God (Almighty) said:

'It is not Al-Birr (piety, righteousness, and each and every act of

obedience to Allah) that you turn your faces towards east and (or)

west [in prayers]; but Al-Birr is [the quality of] the one who

believes in Allah, the Last Day, the Angels, the Book, the Prophets

and gives his wealth, in spite of love for it ... and who are Al-

sabirin (the patient ones) in extreme poverty and ailment (disease)

… Such are the people of the truth and they are Al Muttaqun

(pious)' (Qur'an 2/177).[7]

The everyday practice of Islam is connected to the behaviour, language, spirit

and social traditions of a Saudi citizen. Muslims believe that all human beings are

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[6] The Qur'an, (1989). Surah Fatir, (35/5-6). (Arabic version, Translated by Yusuf Ali) Saudi Arabia:
The Holy Qur'an Complex in Madinah.

[7] The Qur'an, (1989). Surah Al-Baqarah, (2/177). (Arabic version, Translated by Yusuf Ali) Saudi
Arabia: The Holy Qur'an Complex in Madinah.

Allah's servants and are accountable to him for their actions. Death is not the end of human life, but rather the beginning of another eternal world in which the righteous will enjoy the pleasure of Paradise and the wicked will dwell in the intense fire of Hell. Searle and Gallagher (1983, p. 683) point out that Islam is a highly traditional religious and cultural force; it demands strong, dynamic action which, when applied to health, can be a resource against fatalistic and passive tendencies.

The practice of Islam and its associated morals and values are an inseparable part of the culture of Saudi Arabia. A culture that results from the teachings and practice of Islam plays a major role in preparing the social attitude of Saudi peoples' lives: that of being a Muslim (Al-Shahri, 2002). Islam embodies the spiritual, material, intellectual and scientific, and covers all the knowledge, values and the moral commitment to a Saudi's life. Environmental factors, level of education and economic status also play a part in shaping the culture of Saudis (Aldossary, While & Barriball, 2008; Al-Shahri, 2002; Long, 2005; Searle & Gallagher, 1983). However, it is the framework of Islamic beliefs that underlies all the socioeconomic developments in Saudi Arabia (Al-Shaikh, 2007; Doumato, 1999; Littlewood & Yousuf, 2000).

1.2.2 The Issue of Gender

The Qur'an and the Hadith address the roles and responsibilities of both men and women. Islam does not differentiate between male and female, it addresses men and women equally concerning the issue of faith (Turabi, 1988, as cited in Sidani, 2005, p 502). Women are considered capable of carrying out God's commands and are required to do so. The Qur'an states that man and woman 'were created of a

single soul' and are moral equals in the sight of God (Qur'an 7/189).[8] The

participation of women as well as men in the expansion of Islam is evident in its

history, in which there are many instances of women playing a major role (Omar &

Allen, 1996).

Islam gives women spiritual, social, political and economic rights. Several

authors refer to great women in Islamic history who significantly participated in the

spiritual, political and social affairs of their societies (Omar & Allen, 1996; Sidani,

2005). Islam encourages all Muslims to seek knowledge throughout their lives, from

every source possible. Women have the right to divorce, to inherit property, to

conduct business and to have access to knowledge (Doumato, 1999; Omar & Allen,

1996).

During the first few decades of the twentieth century, the Arab world

witnessed the birth of several feminist movements. Women's education and the right

to work in traditional jobs such as medicine, teaching and nursing is now

acknowledged in most of the Arab world and is allowed in religious circles (Sidani,

2005). Haddad (1984, p. 149) stated that the Arab woman is able to become 'the

lawyer, the doctor, the engineer, the cabinet minister, the ambassador, the judge, the

police officer, the paratrooper as well as the nurse, the teacher and the social

worker'.

In Arab countries, female literacy rates have increased threefold in the last 30

years (Sidani, 2005). Figures on Arab development show there have been significant

improvements in addressing women's issues in the Arab world (Arab Human

Development Report, 2002). However, Sidani (2005) argued that participation of

women remains relatively low and differences between various Arab countries have

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[8] The Qur'an, (1989). Surah Al-Araaf, (7/189). (Arabic version, Translated by Yusuf Ali) Saudi

Arabia: The Holy Qur'an Complex in Madinah.

become increasingly evident. Islam is still the major spiritual and social force in the Arab world and in Saudi Arabia, its impact has been pervasive in the lives of people (Long, 2005; Sidani, 2005). In 1960, the Government of Saudi Arabia undertook the introduction of a national education programme for girls (Mufti, 2000). Since the development of KSA, increasing opportunities for women in both education and employment have become evident.

By the mid-1970s, about half of Saudi Arabian girls were attending school. Five years later, education was available to all Saudi girls. By 1980, there were six universities for women (Ministry of Education, 2005). Despite these great efforts, female adult literacy in Saudi Arabia in 2003 was only 87.1 per cent of the male rate. Overall, just 69.3 per cent of females could read and write (United Nations Development Program, 2008). The development of Saudi Arabia has brought with it increasing opportunities for women in both education and employment. Although opportunities for women may exist, the uptake of educational programmes depends on family attitudes, as education for males and females is not compulsory in Saudi Arabia.

The role of Islam in Saudi society cannot be denied. The existing traditions and culture of Saudi Arabia plays a major role in the preparation of social attitudes and in shaping the lives of Saudi man and women. Despite women in Saudi Arabia having gained increased access to education, there are only a few gender segregated job opportunities. Therefore, their participation in the labour-force has been relatively low. Reports show that women account for 55 per cent of Saudi graduates, but that they constitute only 4.8 per cent of the work force. There are an estimated 4.7 million Saudi women of working age (Fatany, 2004).

The position of women in Saudi society is complex and often misunderstood. The social norms in Saudi Arabia require segregation of the sexes in public and

private life. The Qur'an refers to the veiling of women, stating that the Prophet's wives and the women of the believers should draw their cloaks (veils) all over their bodies (Qur'an 33/59).[9] Women in Saudi Arabia are required to wear a headscarf or *khimar* (خمار) and *Jilbaab* (جلباب) covering their hair and in some circumstances they are expected to cover their faces. The Qur'an requires both males and females to behave and dress modestly (Qur'an 24: 30–31).[10]

The issue of segregation between genders is of concern to most Saudi nurses,[11] both males and females. Male nurses are usually restricted to caring for male patients, while female nurses prefer to care for females. Most female nurses and their families will not accept a woman mixing with men. The requirements of nursing are seen as socially unacceptable, opposing the nature of being female. However, nurses recognise that nursing requires working long hours (including night shifts), which takes them away from home (El-Sanabary, 1993, 2003; Tumulty, 2001a). This situation results in conflict for the nurses and their families, which, in turn, impacts on Saudi society.

The religious scholar Ibinbaz (1985) writes that the engagement of women in 'males' domains' separates them from their innate natures (*fitra*), which ultimately leads to women's misery and demise. However, he also asserts that women can work in fields that are a woman's domain, such as female education, nursing and in medical care. Therefore, while religious scholars have no problem with women's education or employment, they emphasise that this is to be done within a framework

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[9] The Qur'an, (1989). Surah Al-Ahzab, (33/59). (Arabic version, Translated by Yusuf Ali) Saudi Arabia: The Holy Qur'an Complex in Madinah.

[10] The Qur'an, (1989). Surah An-Nur, (24/30-31). (Arabic version, Translated by Yusuf Ali) Saudi Arabia: The Holy Qur'an Complex in Madinah.

[11] For the purposes of this research a Saudi nurse is a Saudi Arabian citizen qualified as a nurse.

in which men and women are separated. This is because they see the free mixing of women and men in the work domain as leading to the decay and demise of Muslim society. This has made Saudi society conscious of protecting itself against the mixing of gender in the workplace. This in turn results in a decrease in the ability of women to contribute to Saudi society.

Islam places no restriction on the education or work that Muslim women may undertake (Haddad, 1984; Omar & Allen, 1996; Sidani, 2005), although Islam does forbid women to work with men in the same place and orders a woman to cover her face when leaving her house, as well as to lower her gaze. Muslims believe that God gave beauty to all women, but that their beauty is not to be seen by the world. Muslims believe that when a woman covers herself, she puts herself on a higher level and men will look at her with respect and notice her for her intellect, faith and personality, not for her beauty. God said through the Prophet Mohammed (PBUH):

> 'And tell the believing women to lower their gaze (from looking at forbidden things and one of the forbidden [things] is looking at [a] man) . . . and not to reveal their adornment except to their husbands. And all of you beg Allah to forgive you all, O believers, that you may be successful' (Qur'an, 24/31).[12]

This raises conflict between the need to have a growing nursing workforce and social and religious requirements. This research will examine these conflicts. The next section describes the Health Care System in Saudi Arabia and does so in the light of the cultural and religious influences on health care professionals.

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[12] The Qur'an, (1989). Surah An-Nur, (24/31). (Arabic version, Translated by Yusuf Ali) Saudi Arabia: The Holy Qur'an Complex in Madinah.

1.3 The Health Care System in Saudi Arabia

1.3.1 History

King Abdul-Aziz established a system for medical care in 1926. He introduced a 'Health Department' for the people of Saudi Arabia (Mufti, 2000). The Health Department was renamed the 'General Directorate for Health and Aid' and was appended to the Attorney General. Within the General Directorate, the health council was set up to improve standards of health, plan essential decisions to avoid epidemics and maintain public health, especially during the pilgrimage (*Hajj*) season (Mufti, 2000). During the annual Hajj, thousands of people come from different parts of the world to perform and complete one of the five pillars of Islam—the pilgrimage to Mecca. The Hajj involves personal and financial sacrifice and is an act of worship. Muslims must make the pilgrimage during the first half of the last month of the lunar year: Dhu al-Hijjah (Matar, 2001).

The director of public health is the official responsible for the implementation of council decisions. The council has to ensure recommendations are carried out, as well as keep the government informed of health-related issues. Due to limited health care facilities, progress in providing health resources was extremely slow in the past, with the total number of hospital beds before 1946 being only about 300. Health care was provided free to the population of Saudi Arabia, but in 1946, health care facilities were insufficient to cover all the geographical regions of the growing country (Jannadi, Alshammari, Khan & Hussain, 2008; Mufti, 2000). From 1946 to 1950, the government health sector witnessed rapid improvement, with more hospitals and health care centres being established in most regions throughout the country. Prior to the 1960's, traditional forms of health care were still popular (Mufti, 2000) and appeared contradictory to modern medicine. However, by 1960,

there were 1,300 hospital beds. With the rapid social and economic development of the country, one critical goal was the growth of accessible health care for the entire population of Saudi Arabia. As Gallagher and Searle (1985, p. 251) state: 'Advancement toward a national framework of health services which embodies equitable access and technological progressiveness is occurring rapidly'.

1.3.2 The Modern Health Care System

The current health care system in KSA involves a number of government agencies and the private sector. The Ministry of Health (MOH) is the government agency with overall responsibility for public health care. As shown in Table 1.1 the MOH is the primary and original health provider, offering about 60 per cent of the health services and 63 per cent of the total number of beds in Saudi Arabia (Al-Yousuf, Akerele & Al Mazrou, 2002; Mufti, 2000). Other major health providers are the Ministry of Defence and Aviation (Armed Forces Hospital in Riyadh) providing 8 per cent of hospital beds, National Guard Hospitals (3 per cent) and teaching hospitals (7 per cent). These three sectors comprise 13 per cent of the total hospitals and 21 per cent of hospitals beds, while private hospitals provide the remaining 20 per cent of services in KSA.

Table 1.1

Health Services Provided by Health Sectors in Saudi Arabia

No.	Health Sectors	Percentage of Health Services Provided	Percentage of the Total Number of Hospital Beds
1	The Ministry of Health	60%	63%
2	The Ministry of Defence	8%	21%
3	Teaching Hospitals	7%	
4	National Guard Hospitals	3%	
5	Private Hospitals	20%	16 %
6	Other Agencies	2%	

The MOH is the government agency responsible for health policies and planning. Saudi Arabia has 19 health regions administered by directors who are responsible to the Minister for Health (Al-Yousuf, Akerele & Al Mazrou, 2002). In each region, the authority of the General Directorate of Health Affairs (GDHA) is responsible for all the hospitals, health care centres, equipment, technical and managerial staff (MOH, 2008). The provision of public health care is organised through a referral system into a network of primary health centres and general and specialist hospitals. Hospitals controlled by defence and National Guard, for example, service their employees and their families.

The total number of operational hospitals in the Kingdom currently stands at 379 hospitals, of which 256 are administered by the public sector and 123 by the private sector (Al-Shaikh, 2007; MOH, 2006). The total number of MOH hospitals in 2007 was 220, while MOH Primary Health Centres numbered 1925. The other major government health providers service 39 hospitals. There are 127 private hospitals and 1,057 private health centres (MOH, 2008). Hospital beds, for both the public and private sectors, total 53,192, bringing the Kingdom's hospital beds per 1,000 population to 2.25. The average hospital size is 140 beds (Al-Shaikh, 2007).

Saudi hospitals are unable to be fully staffed by Saudi nurses, as the numbers of Saudis willing to become nurses is small. The government, because of the availability of expatriate nurses, does not see the need to encourage Saudi people to become nurses. In 2002, the total number of Saudi nurses working at MOH hospitals was 12,263, which represented 32.3 per cent of the nursing workforce, while the total number of non-Saudi (expatriate) nurses was 67.7 per cent (25,655) (MOH, 2006). These figures only represent MOH hospitals.

The Government has plans to increase the national Saudi nursing staff. According to the World Health Organization (WHO), the priorities of the Saudi government are to develop and improve teaching staff, health administrators, management and nursing administration (WHO, 2007). An interesting omission from these priorities is to develop the skills base of nurses. If the experiences of the Saudi nurse are not fully understood, then any attempt to create a positive working environment may fail. The next section explores further the experience of being a Saudi nurse.

1.4 Background of the Research

1.4.1 Nursing Status in Saudi Arabia

With rapid change in the national health care system, the notable increase in the number of hospital beds and an increase in health care facilities in both the government and private sectors, Saudi Arabia is encountering a significant shortage of qualified Saudi nurses. There are a number of factors contributing to this shortage. Al-Ahamdi states that these include 'difficulties arising from salaries, shift schedules and the social perception of nurses' (2002, p. 645). This is in addition to the many other issues relating to retention and professional development and the social issues that face an individual who chooses nursing as a career. These issues include:

- Level and adequacy of qualifications

- Inadequate training and preparation

- Lack of resources

- Lack of a research focus to help improve practice

- Inadequate English language skills with which to communicate with expatriate peers

- A poor public image and recognition

- Meagre remuneration

Evidence indicates that many Saudi nurses leave nursing work due to social and professional pressures (Abu-Zinadah, 2006). However, there is a lack of research on the experiences of Saudi nurses in relation to overcoming these challenges. Evidence in the literature concerning the social and professional pressures experienced by Saudi nurses is rare and often written by expatriates who may present a biased view. For example, differences in background, communication and perception may result in varying interpretations. Saudi people hold in common their social customs and these are held only by Saudis. Conversely, an expatriate might judge the value of Saudi culture by reference to his or her own cultural perspectives.

Importantly, if Saudi Arabia does not address the retention of Saudi nurses and improve on the current situation, the attrition of Saudi nurses will continue. In the context of Saudisation (the gradual replacement of expatriates with qualified Saudi citizens) (Mufti, 2000), Saudi Arabia may never be able to have sufficient Saudi nurses for safe patient care. Meanwhile, Saudi nurses are not practicing their skills, instead moving into other unrelated areas and earning similar wages. Some nurses work in social work departments, as secretaries in hospital administration or in other departments.

Saudi females commonly leave the profession after marriage, as their husband may not approve of their wives working (El-Sanabary, 1993, 2003) or because family responsibilities are greater than the need to earn money. Saudi women are not able to drive and there is limited public transport. They must rely on a male relative to transport them to and from work. If their husband, father or brother does not approve, then the female nurse is unable to get to the hospital at which she

is employed. Saudi women usually do not travel in taxis on their own, as the drivers are male.

Nursing administration is often in the hands of international staff and there is a lack of opportunity for Saudi nurses to take on leadership roles (Tumulty, 2001a). One reason for this is the level of education. Western nurses, as an example, are able to gain post-basic qualifications in management, whereas these courses as a rule have not existed within the Kingdom. In addition, in specialist areas, there are very few postgraduate courses at University level. This, coupled with the low status of nursing in the community, provides little incentive for Saudi women to embark on a nursing career (El-Sanabary, 1993; Tumulty, 2001a).

Consequently, there is a necessary and substantial reliance on overseas (expatriate) nurses to meet the health needs of the population of Saudi Arabia. There is a critical need for Saudi nurses who are sensitive to patients' cultural and religious needs. Continued reliance on expatriate nurses affects the nature of the care delivered to Saudis. Expatriate nurses do not fully understand the Saudi culture and language. Therefore, problems arise that prevent adequate patient care. Improving the situation of Saudi nurses is critical. Nurses themselves are the best resource for the development of their profession. In this time of nursing shortages and demands to increase or recruit more nurses, it is crucial to identify the opinions and attitudes of nurses if we are to change the situation to best prepare new nurses to be competent and effective.

Current advances in science and technology mean nurses must continue to develop and improve. Even experienced nurses require a continual updating of skills and knowledge to develop their practice. Positive professional development may also influence nurses' feelings about responsibilities and offer an opportunity for all nurses to participate and extend nursing care (Gregg & Magilvy, 2001; Rogers,

2009). In this context, professional development for current nurses could contribute to increased satisfaction with the nursing role and provide improved staff retention. Without a change in the image and social understanding of nursing, any change in the development of practice will not have the desired effect.

It is also essential for nurses to be reflective; that is, to be able to identify and assess their own views and performance in their existing roles, so that continuing professional education can be planned. The perceptions and experiences of Saudi nurses need to be examined to improve the quality of their nursing and practice standards, as well as their professional status. However, to date, there has been minimal research exploring how Saudi nurses view themselves, their profession or their future. It is therefore intended that this study will use a phenomenological approach to uncover the experience of being a Saudi nurse, including their perceptions on their nursing practice, professional development and career opportunities.

This thesis will argue, based on the findings, that current nursing models and frameworks in nursing practice in Saudi Arabia are not consistent with the Islamic viewpoint, in that they do not reflect the Islamic perception of caring (McKennis, 1999; Rassool, 2002). This causes problems in the retention of Saudi nurses, with 50 per cent of graduating Saudi nurses leaving the profession due to social and professional issues (Abu-Zinadah, 2006). The resulting job vacancies are filled by expatriates, who, as has been mentioned above, comprise the bulk of the health care workforce. Consequently, in its current state, nursing as a profession is unable to meet the needs of either Saudi nurses or Saudi patients (Tumulty, 2001a). This is a critical cultural problem as will be demonstrated in Chapter 6.

It is argued in this thesis that the shortage of Saudi nurses has more to do with the quality of nurse education in Saudi Arabia and neglect once the nurses enter

the nursing profession, rather than with a lack of potential supply of Saudi nurses.

Saudi Arabia suffers from a large number of unqualified Saudi nurses (Abu-Zinadah,

2006; Tumulty, 2001a). These nurses have not been prepared adequately to be

nurses. Therefore, they encounter problems in their profession. There are also

contradictions in nursing management that contribute to the problems and outcomes,

such as evidenced by the Assistant Minister for Planning and Development at the

MOH, who stated in October 2007 that more than 3,000 male nursing graduates were

on waiting lists for jobs (Shalhoub, 2007).

The primary difficulties Saudi nurses encounter in their education and in

carrying out their jobs—the barriers they encounter in practical situations—have

never been qualitatively exposed. Changing the state of affairs in Saudi nursing is a

priority if nursing is to become a profession equal to what it is in Western countries.

Nursing in Saudi Arabia continues to be controlled by the medical profession, which

views nursing as a dependent group. From a management perspective, Tomey

(2000) and Ellis and Hartley (1999) have emphasised that no profession can provide

suitable and qualified services unless its members feel power and have control over

their own functions. The Saudi Nursing Council (SNC), established in 2000, has not

effectively established Saudi nursing as an independent profession. The SNC

operates exclusively as a regulatory body in nursing and has not yet been able to

make the system accountable to either Saudi nurses or the public.

The nursing profession in Saudi Arabia has been dependent on non-Saudi

nurses since organised medical care was first implemented in 1926. Over the same

period, the nursing education system has failed to adequately qualify native nurses

according to international standards. According to Mufti (2000), there is a growing

awareness that unless some radical steps are taken, the long-term sustainability of the

system may be in jeopardy. Sustainability in this case can be defined as the ability to

meet the needs of the present world without compromising the ability of future

generations to meet their own needs (Bersani, 2008; Edwards, 2005; Mufti, 2000).

Bersani (2008) commented that the difficulty of gathering accurate and relevant data

hinders the ability for internal change. Therefore, it is difficult to discuss

sustainability when the data available may not reflect reality. Bersani (2008, p. 34)

states:

> 'Sustainability is a systemic concept that, according to the World
>
> Commission on Environment and Development, relates to the
>
> continuity of economic, social, institutional and environmental
>
> aspects of human society … sustainability is the long-term
>
> compatibility between the economic and the environmental and the
>
> social dimensions of development.'

In terms of ensuring sustainability in nursing, Saudi nurses strive for

professional autonomy and to participate in the development of their profession.

Nursing should be involved at all levels of professional development, nursing

research, health policy change and professional decision making. This will help

improve, develop and sustain the nursing profession in Saudi Arabia. The search to

understand the reality of nursing in Saudi Arabia from both a personal and academic

perspective has resulted in the development of this thesis. In the following section,

the research focus, aim and potential significance of this thesis will be discussed.

1.4.2 Aim of the Research

Using a phenomenological framework, the meaning of being a Saudi nurse

will be explored. This research aims to explain the experience of being a Saudi nurse

and to identify the needs Saudi nurses have, based on their understandings of their

development and practice as nurses.

1.4.3 The Potential Significance of the Research

Research in nursing in Saudi Arabia is in its infancy and most of the research that has been conducted has not been published. Certainly, in any research so far undertaken, nursing from the Saudi nurse's perspective has been largely ignored. To contribute to the body of knowledge, this qualitative research will focus on the experience of Saudi nurses in relation to their professional development, practice and career opportunities.

Nursing organisations must pay attention to the perspectives of their members, and others, in determining the best way forward. The organisational development of an organisation provides its members with the competence and motivation to adjust ineffective models of human behaviour (Harey & Brown, 2001; Knowles, 1999). Therefore, in nursing, organisational development necessarily involves the co-ordinated effort of both nurses and their management. Harey and Brown (2001, p. 4), among other management theorists, have defined the concept of organisational development as 'an emerging discipline aimed at improving an organisation's ability to survive by changing its problem-solving and renewal processes'. Organisational development is based on the belief that for an organisation to be effective and accomplish its goals it must be more than merely efficient; it must also adapt to change (Harey & Brown, 2001). Hendrich and Chow (2008) and Ellis and Hartley (1999) noted that organisations that value their members empower them, keep them informed and assist them to feel secure. Saudi nurses must be considered as part of nursing organisations and their lived experiences should not be undervalued.

This research provides a description and explanation of what it is like to be a Saudi nurse. More significantly, it provides a Saudi nursing context, which is important because there is much evidence that the critical insights in the field are

context-specific (Costello, 2005; Knowles, 1990). If one is to really understand the lived experiences of nurses, it is necessary that they be presented by those who are well acquainted with the culture in which they are to be observed (Gregg & Magilvy, 2001; Leininger, 2002a).

This research is significant in regard to the development of Saudi nursing knowledge, and in terms of understanding the experiences and perceptions of Saudi nurses. By examining the difficulties they encounter, it also has implications for potential future nurses deciding on a career. In addition, this research may identify the impact of the image Saudi nurses have of themselves and their practice, and provide direction for improving the factors that negatively impact on the professional standing of nurses. By uncovering these issues, they can be brought to the notice of the Government and solutions can be sought and implemented.

It is hoped that this will lead to improvements in how nurses are perceived and accepted by Saudi society. After all, when nursing care is improved, so are the health needs of the Saudi community. Within nursing the benefits may lead to new insights about nursing's identity within Saudi Arabia and this may empower nurses. As competent and highly qualified professionals, nurses should be able to take control of nursing and their career advancement. Ideally, at the bedside, Saudi people should have nurses who speak their language and understand their religion, which will improve patient care and safety by eliminating communication errors. In time, the country may experience reduced health costs as a result of the reduced reliance on expatriate nurses.

1.5 Structure of the Thesis

The next chapter establishes the need for this research. It describes the relevant aspects of the nursing profession in Saudi Arabia and looks more

specifically at the discipline of nursing as a profession, as well as its history and relation to Islam, which is significant in this research inquiry.

A detailed description of phenomenology as a research methodology and its relation to experience is explained in Chapter 3, and clarification of the research method and the approach chosen in this inquiry is presented in Chapter 4.

Chapter 5 concerns the design of this research, including the framework, which utilises van Manen's methodological approaches to phenomenological research. Two major classifications emerged as a result of the research investigation and these are presented in Chapter 6, in which the findings reveal the meaning of the lived experiences of Saudi nurses.

After the essence of being a Saudi nurse is revealed, Chapter 7 returns to the literature, primarily in regard to how it relates to the findings. Chapter 8 discusses the research findings in relation to the existing nursing literature, phenomenology and Islamic perspectives. The concluding chapter—Chapter 9—explores the overall value of the project and concludes with relevant recommendations.

Chapter 2: Literature Review

2.1 Establishing the Need for the Research

2.1.1 Introduction

From a phenomenological standpoint, the literature review may be divided into two parts: the first part establishes the need for the research and the second part (see Chapter 7) explores the research findings and their relation to nursing literature.

This thesis is about Saudi nursing. Through the findings, it identifies the inadequacies of Saudi nursing in many critical areas. It also highlights the influence of a constraining educational system, both in general and in regard to its effect on Saudi nursing. In addition, the general lack of accredited standards in nursing courses affects the quality of training received by and thus the preparedness of Saudi nurse. How Saudi society views nursing also contributes to the nature of the profession, with a nurse's career choices, as well as the career choices of potential Saudi nurses, being influenced negatively by misconceptions held by society as a whole: nurses' issues in Saudi society are often hidden and mistakenly connected to Islamic viewpoints that centre on concerns surrounding female education and participation in nursing.

Nursing is a universally recognised profession, appearing in some form in every culture (Huber, 2006). Advances in technology and population growth have increased the demand for nurses. However, there is a shortage of qualified nurses worldwide (Chiha & Link, 2003). Nursing as a profession is facing critical issues (see Section 1.5.1) and the shortage of qualified Saudi nurses is acute throughout the nation of Saudi Arabia.

Saudi Arabia relies upon qualified expatriate nurses to meet its health care needs. Only a small number of Saudi nationals are employed (Almalki, FitzGerald & Clark, 2011; Prescott, 2003). However, because of the unrest in the Middle East from the time of the Gulf War to the war in Iraq, many expatriate nurses are not attracted to work in Saudi Arabia and have left. Yet Saudi Arabia needs nurses: it is estimated that 100,000 qualified Saudi nurses will be required in the next 10 to 15 years to meet the demand for health care (Ghazanfar, 2004; Saudi Press Agency, 2004).

Saudi nurses are not well-trained or educated. They also face many problems that are not often experienced in other parts of the world. To improve the health status of Saudi society, the health care system needs more nurses and requires current nurses as a group to improve their skills and work practices.

Due to inadequate education, career opportunities for Saudi nurses are lacking. Further, after initial formal training is completed, nursing organisations do not offer good professional development opportunities or work practices for Saudi nurses. Moreover, there is no university in Saudi Arabia that offers a degree in nursing for male nurses. Nursing programmes have failed to adapt to the needs of Saudis who are willing to work within the framework of Islamic practices of caring and who are willing to become qualified nurses. After graduation, Saudi nurses experience various difficulties in their profession that cause disappointment and low expectations. Consequently, Saudi people are less likely to apply for nursing courses or consider nursing as a future career.

In exploring the nursing profession in Saudi Arabia, it is useful to begin with a general overview of the literature and examine the discipline of the nursing profession from different viewpoints. However, it is important to note that the

majority of the literature that has contributed to the nursing profession in Saudi

Arabia has been written by non-Saudi researchers.

The following questions need to be addressed:

- How do Saudi nurses experience nursing?

- How is the experience of Saudi nurses who have left the profession

  different from those who are still nursing?

- How is nursing in Saudi Arabia different from nursing in other countries?

- How does Saudi culture affect nursing for Saudi nurses?

- What are the needs of the nursing profession in Saudi Arabia now?

Literature relevant to these questions is either lacking or non-existent. This

chapter will highlight the literature that has been written, while an exploration of the

life-world of the participants will answer the remaining questions.

Most literature about nursing in Saudi Arabia is quantitative with descriptive

findings. These quantitative findings do not necessarily provide a pragmatic

understanding of the nature or essence of the Saudi nurse's experience, although they

are still helpful. As Shaw (1993, pp. 154–156) states:

> 'If the discipline of nursing is dedicated to excellence of care
>
> through the advancement of knowledge, then to reject quantitative
>
> research methods due to fear of dehumanizing patients with
>
> reductionist methods would be an epistemological error.'

However, it is the qualitative paradigm that is most relevant and which

should exist alongside nursing practice. The heritage of nursing is calling nurses to

utilise their lived experiences, share their stories and move beyond the notion of

communication and negotiation to a strong commitment to social action (Cowen &

Moorhead, 2006a).

To begin the review, in the context of the history of nursing, it is necessary to highlight that nursing in Saudi Arabia is not in step with contemporary nursing in the developed countries.

2.1.2 The Discipline of the Nursing Profession

'The importance of the role of nurses [is] not only related to treatment but also to assisting people in decision making since many decisions about which course of treatment to follow are not so much medical decisions, but personal decisions that should be made by the patient and/or his or her family' (Marles, 1988, as cited in Heath, 2002, p. 81).

The historical roots of nursing as a discipline can be traced back to the first recognised contemporary nurse, Florence Nightingale, who viewed nursing as a profession with organised concepts and social relevance distinct from medicine (Andrist, Nicholas & Wolf, 2006; Leininger, 1992). The WHO (2000) later clarified that nursing as a discipline is an organised service designed to meet the needs of the individual, family and community in health and disease (Shaw, 1993). Nursing has become one of the vital health activities contributing to improving human health and restoring individual health in the event of illness. Now, nurses in every culture help people determine and achieve their health care goals. Cowen and Moorhead (2006b, p. 322) state:

'The structures in which nursing has been practiced through the years sometimes have been a constraint to the ability of professional nurses to govern their own practice. In the changing terrain of health care at the turn of the millennium the entire field is

shifting, offering unusual challenges for nursing to play a more

prominent role in governance issues.'

This is especially evident in Saudi Arabia. The health and nursing workforce

has advanced in education, training and professional standing in all developed and

developing countries (Barrett, 2006; Chan, 2002; Crotty, 1993; Leininger, 2002a;

Luna, 1998). Many countries have implemented formal qualifications for the nursing

profession to ensure nurses hold the required skills and knowledge (Chinn, 2006;

Leininger, 1991; 2001; Washington, 2006). Training facilities have also been

established to provide nurses the opportunity to keep their skills current. Developed

countries demand that courses are accredited by a government body to ensure

standards. However, this accreditation does not exist in Saudi Arabia.

In 1859, Nightingale (p. 6) outlined her understanding of what nursing should

be. Nightingale (1859, p. 6) said:

> 'I use the word nursing for want of a better. It has been limited to
>
> signify little more that the administration of medicines and the
>
> application of poultices. It ought to signify the proper use of fresh
>
> air, light, warmth, cleanliness, quiet, and the proper selection and
>
> administration of diet—all at the least expense of vital power to the
>
> patient.'

In addition, Nightingale (1859, p. 6) believed that 'the very elements of

nursing are all but unknown. The art of nursing, as now practiced, seems to be

expressly constituted to unmake what God (Almighty) had made disease to be'.

Nightingale goes further to claim that nurses lacked knowledge regarding 'those

laws which God has assigned to the relations of our bodies with the world in which

He has put them' (p. 7).

Regardless of differences in definitions of the profession, four common characteristics of nursing are widely accepted and often cited in nursing literature. These are that the profession has autonomy, a specialised body of knowledge, a professional code of ethics and it provides a service (Billeter-Koponen & Fredén, 2005; Castles, 1987; Joel, 2006; Keogh, 1997; Oweis, 2005). Autonomy means 'self-government or self-rule' (Johnstone, 2000, p. 38). This basically means that nurses should be able to make decisions in their profession. Within their life-world, nurses need to be able to influence how their profession operates and how nurses are trained and prepared for their profession.

The second characteristic is a specialised body of knowledge. Professional activity often involves organised knowledge and proficiency in certain skills and processes (Joy-Matthews, Megginson & Surtees, 2004). A specialised knowledge of a subject matter is usually involved and applied. The growth of nursing knowledge is evidenced by the growth and depth of nursing research and public debate on nursing issues. As in other professions, the continued growth of knowledge relied on life-long learning, as put forward by Joy-Matthews, Megginson and Surtees (2004).

The third common nursing characteristic is a Code of Ethics. Joel (2006, p. 337) states that 'a code of ethics is considered an essential characteristic of a profession, providing one means whereby professional standards may be established, maintained, and improved'. Unfortunately, nursing in Saudi Arabia struggles to fulfil these four criteria, prompting some researchers to question whether nursing in Saudi Arabia is actually a profession. This will be discussed later in this chapter.

2.1.2.1 Trans-Cultural Nursing Knowledge

The terms cultural, cross-cultural and transcultural are used in many different ways. Cross-cultural and transcultural nursing cannot be separated from the context

of the cultural beliefs of nurses and the societies in which they work. Saudi nursing involves expatriates from many nations as well as a small numbers of native Saudis. From this, stem issues concerning Saudi nurses caring for both Saudi and non-Saudi patients, expatriate nurses caring for Saudis and gender-specific nursing influenced by cultural and religious beliefs.

Nursing explored at a cultural level varies significantly. According to Benhabib (2002, p. 2), 'culture refers to forms of expression through which the "spirit" of one people, as distinct from others, is voiced', while civilisation 'refers to material values and practices that are shared with other peoples and that do not reflect individuality'.

Saudi culture affects Saudi nursing whether experienced by Saudis or expatriates. Nursing in Saudi Arabia is affected by many cultural issues, especially in relation to language, gender and religion. 'If cultural issues are taken into account, among others, in a fuller accounting of societal change, they can greatly help to broaden our understanding of the world, including the process of development and the nature of our identity' (Sen, 2006, p. 108). Culture is thus an abstract concept that integrates patterns of human behaviour including language, beliefs, thought, communications, actions, values, customs, ethnicity and spirituality (Meleis & Lipson, 2004).

The premise that caring is culturally constituted is supported by several authors. Nursing is about caring, and the ability of Saudi nurses to care depends on the cultural influences which impact upon nurses in Saudi Arabia today. In the early 1950s, Leininger (1984, as cited in Omeri, 2002, p. 518) stated that 'care and culture are two major and closely interrelated concepts that need to be systematically studied as transcultural nursing knowledge and practices'. In the mid-1950s, Leininger coined the term 'transcultural' nursing as a formal area of study and practice for nurses (Leininger, 1992, 2002b). Transcultural nursing is viewed as 'the next level of

liberation, this time from the "prison house of language", from unconscious predispositions and prejudices of the "native", naturalized cultures' (Epstein, 2009, p. 327).

Andrews and Boyle (2002) point out that transcultural nursing is not just for immigrants or people of colour, but enables us to view our profession from a cultural perspective. Brink (1994, p. 344) describes transcultural nursing as referring to concepts such as 'healing and caring that are universal and transcend cultural boundaries'. All cultures have these universal concepts (Meleis & Lipson, 2004). Kissell (2009, p. 70) writes:

> 'As a social good, health care cannot be a commodity, but rather something necessary to all of us if we are to live more and to be more … we should fit our methods of distribution to the meanings of the goods we have in a society to distribute. A good such as health care that is so intimately tied up to what it means to be human should be available to all.'

This is very relevant to nursing in Saudi Arabia, and to the research question of what it is like to be a Saudi nurse. However, the experiences of nurses themselves also need to be considered from a cultural viewpoint, for which there is a need to transcend and represent the intent of Saudi nurses within the context of their culture. Saudi nurses need to be aided in transcending issues relating to religion and culture, and in providing their desired standard of nursing. The constraints society and culture place on nursing should be overcome, so that nurses are no longer neglected.

The meaning of being a nurse is an important element that needs to be carefully considered. The emphasis on the meaning of being a Saudi nurse will help this research focus on their intentional experiences. This is reflected not only in the

type of the data collected, but also in the personal characteristics of those nurses

interviewed, 'especially in their motives, attitudes, and skills or abilities' (Knowles,

1990, p. 261). The intended meaning the interviewed nurses try to convey is a

critical part of the meaning actually perceived and interpreted by the researcher. The

meaning of being a Saudi nurse facilitates action, without which, nursing and nurses

stagnate. Conversely, in taking seriously what it is like to be a Saudi nurse, new

ideas come to be generated, accepted and implemented.

Nursing as a profession is a learned career and deserves the respect and

support that is shown to any other profession. However, as the education of Saudi

nurses has been insufficient so far, Saudi nurses must move beyond self-interest to

achieve their main goal of improving their profession. Likewise, nursing authorities

in Saudi Arabia must consider the needs of Saudi nurses. They must do this

alongside an awareness of the Islamic perspective and ensure organisational

objectives and cultural competencies that fit with the culture of Saudi Arabia. Bass

and Steidlmeier (1999) state that nurses need direction from higher authorities. This

direction should not be arbitrary and without rationale or understanding.

A review of the history of nursing in Saudi Arabia reveals the problems

Saudi culture has created for Saudi nurses. Change is unlikely to occur without

knowing and understanding of the lived experiences of Saudi nurses, collected using

the techniques of nursing research.

2.1.2.2 Research in Nursing: The Development of Knowledge

There is widespread agreement in nursing literature that theory is important

for the growth and development of the nursing profession, as theory helps nurses

determine and achieve explicit practical goals (Alligood, 2010a). As nursing is a

knowledge-based discipline committed to the improvement of humankind (Fawcett,

2006; Huber, 2006; Shaw, 1993), research is a necessary part of continuing and building the discipline. Regarding Saudi nursing, uncovering the factors that have affected or discouraged Saudi nurses will illuminate the current situation of nursing in Saudi Arabia. This investigation will allow the researcher to observe the phenomena of interest in the lived experiences of Saudi nurses, 'in a manner so closely related to how they nurse, that is, in context, without prejudice and holistically' (Lyneham, 2004, p. 141).

The nursing profession, according to Anastas (1999), has often sought to strengthen its knowledge base and its claims to legitimacy among competing professions through research. In addition, Anastas claims that the profession has also placed emphasis on the importance of its resources and the theoretical foundation for its methods and its goals.

In Saudi Arabia, research opportunities for nurses are limited. Research conducted by Saudi nurses is usually conducted when studying outside of Saudi Arabia and is largely unpublished. Research conducted by non-Saudis indicates that the entire nursing profession in Saudi Arabia needs to be carefully analysed and that changes are needed if nursing is to achieve the outcomes it seeks (Luna, 1998; Tumulty, 2001a). Many of these required changes have to do with a better understanding of how culture affects nursing practice. It is anticipated that the present emphasis on theory and practical evaluation will enhance the future development of nursing knowledge (Alligood & Tomey, 2010; Castle, 1987; Fawcett, 2006; Wood, 2010). In Saudi Arabia this will only occur when the findings can be adapted to and replicated in the Saudi context.

To understand how culture affects nursing practice, the current professional literature on caring promotes the concepts of reflection and reflective practice for the nursing professional (Cowen & Moorhead, 2006b). Nurses are now recognising the

need for professional self-awareness, and the ability to reflect on their practice. This is critical for Muslim nurses, who need to take (or be given) more influence and control over their profession. In nursing literature, many authors draw on the latest research and on their experience to provide nurses with a practical and accessible guide to reflection on every day nursing practice (Bowden, 2003; Bulman, 2004; Lyneham, 2004). Experts in the field provide help for nurses to develop and challenge their nursing knowledge, skills and values through reflective practice. The value of reflective practice becomes clear when nurses reflect on themselves as professionals and as human beings in a practical situation (Begat & Severinsson, 2006). Moreover, according to Lyneham (2004, p. 275), 'reflective practice enables the nurse to know where to direct their research and experience'. With the aid of reflection, this research aims to uncover the primary issues that concern Saudi nurses and to explore potential solutions.

The intention here is not to explain how to be reflective, as there is already an abundance of literature on the influence of reflection and its involvement in the process of critical thinking. Reid (1993, p. 305), for example, defines reflection as 'a process of reviewing an experience of practice in order to describe, analyse, evaluate and so inform learning about practice'. Within this process, there is a clear connection between intuition, experience, knowledge and reflection. As Lyneham writes, 'without reflection or reflective inquiry the translation of theory into practice is all but impossible' (2004, p. 72). This means that Saudi nurses need to learn certain skills and knowledge and develop attitudes and attributes that allow them to achieve their objectives in a practical way.

Reflection is an important characteristic required to support nursing theory in Saudi Arabia. As part of the process of critical thinking, it is not to be overlooked, as effective nursing practice requires the application of the concept of reflection. The

significance of its contribution will help Saudi nurses increase their knowledge and allow them to provide the desired care within the context of their culture. Reflection requires nurses to be critical thinkers, which may assist the development of Saudi nursing within the context of its culture. The concept of reflection is important in the development of nursing as nursing development requires 'knowledge and a reflection on knowledge as it relates to practice and the force that permits the two to fuse and become significant' (Lyneham, 2004, p. 102).

The discipline of nursing involves knowledge that derives from both scientific and humanitarian perspectives (Alligood, 2010a; Harris, 2004; Musker, 2011). On a global scale, the law regulates nursing practice and enhances and supports nursing performance. Knowledge of nursing is the foundation for action in clinical practice. This knowledge is obtained from systematic inquiry, including an examination of philosophical assumptions and the history of nursing, as well as education in practical methods (Huber, 2006; Shaw, 1993).

The following section looks at research into the history of nursing in Saudi Arabia and examines the current nursing situation.

2.1.3 Nursing in Saudi Arabia

The current state of nursing in Saudi Arabia is complex. Many factors affect nursing , with most stemming from the cultural environment. However, before proceeding to the current situation of nursing in Saudi Arabia, a brief examination of the history of Saudi nursing is warranted.

2.1.3.1 The History of Nursing in Saudi Arabia

Nursing in Saudi Arabia is a relatively new profession compared to nursing in the West, and the history of nursing in Saudi Arabia prior to the 1960s is difficult to find sources for due to a lack of published literature in this area. Little has been

written about nursing in the pre-Islamic period (before 570 AD) (Miller-Rosser,

Chapman & Francis, 2006; Tumulty, 2001a). As Miller-Rosser et al. (2006, p. 2)

commented:

> 'Documents from the Islamic period … reveal few references to
>
> nursing. Ancient medical systems consisted of treatment solely by
>
> doctors, who would visit the patient at home, prescribe medicines
>
> and expect the relatives to provide ongoing care. Thus, there was
>
> little need for [formal] nurses [because the females in the family
>
> fulfilled this role].'

Despite women being denied many rights before the beginning of Islam

(Sidani, 2005), during the time of the Prophet of Islam (PBUH), nursing changed.

The nursing profession flourished in the time of the Prophet Mohammed (Barolia,

2008; Jan, 1996; Miller-Rosser et al., 2006). He allowed women rights that

previously they had never been granted before, such as the right to be a nurse and

care for others. Many Muslim women have been acknowledged as giving direct

physical care to their brothers during the time of Prophet Mohammed (Sidani, 2005).

'These women were well educated and skilled in providing physical and emotional

comfort and care' (Jan, 1996, p. 267).

Islamic nursing begun with Rufaida Al-Asalmiya during the time of the

prophet Mohammed (570–632 AD) (Jan, 1996; Miller-Rosser et al., 2006; Tumulty,

2001a). Rufaida has been reported to be the first Muslim nurse. She learned her skills

in nursing before converting to Islam, through her father, who was an important

healer (Jan, 1996). There were other prominent Muslim women who provided food

and care for injured soldiers on the battlefield. 'Rufaida not only provided care to

injured soldiers in deserts and battlefields, she was also a Muslim social leader and

educator' (Jan, 1996, p. 267). She was a daughter of Saad Al-Aslamy, a healer in Al-Medina (the second holy city) in Saudi Arabia. According to Jan (1996), Rufaida assisted him and, during this time, she developed her nursing skills. She was known to be patient, kind, devoted and committed to her duty. In addition, she organised a team of Muslim women and young girls to train them in nursing. She trained 'her closest friends and co-workers' (Jan, 1996, p. 267).

According to Jan (1996), when Rufaida became a Muslim, the Prophet allowed her to practice her skills and provide care to the wounded soldiers during the Holy battle. Rufaida Al-Asalmiya has not been widely recognised and her service to the community of that time has been almost forgotten (Jan, 1996, p. 267). However, she has been a significant influence on and inspiration for nursing in Saudi Arabia. Rufaida was not only a leader in Muslim society and in health care, but 'her most renowned contribution was to establish the first school of nursing for women' (Jan, 1996, p. 267). According to Jan, Rufaida also developed the first code of nursing conduct and ethics, many centuries before nursing was introduced by Nightingale. 'Rufaida was a role model in the noble profession of nursing … She was well organized. She planned and prepared her team with the necessary education and skills' (Jan, 1996, p. 267).

Through the tent that she established in the mosque, she taught her friends, provided care (Jan, 1996) and advocated for preventive care and the recognition of the importance of health education. She initiated a tradition of providing health-related education in the Mosque. 'Because of Rufaida we realize that nursing is a noble career for Muslim women in accordance to Islamic tradition' (Jan, 1996, p. 268).

Few historical records of nursing or the nursing profession exist from the era following the death of the Prophet Mohammed (PBUH) in 632 AD (Jan, 1996;

Miller-Rosser et al., 2006). What does exist consists mostly of commentary by philosophy scholars and physicians such as Ibn Sina and al-Razi. During the Islamic era, al-Razi was a scholar, generous teacher and physician. He provided food and other resources to the poor as well as providing for their nursing needs.

It is worth noting that throughout the history of Islam there have been many instances of scholars going beyond their theoretical pursuits by delivering care to individuals on a hands on basis. Further, some scholars have taken on the work of physicians and nurses, both trying to cure patients, but also serving them food. Scholars of Islam were more practical than theoretical in their intention to practice and treat others. This approach would be most useful in nursing today.

During the Middle Ages, there were developments in nursing, such as separate male and female wards and male and female nurses caring for their own gender (El-Sanabary, 1993; McKennis, 1999; Rassool, 2000). This is an important development because this is still relevant to Saudi Arabia today, where many traditional values reflect 'past segregation practices' (El-Sanabary, 1993; Miller-Rosser et al., 2006).

More recently, other notable nurses have had an influence on the profession. These include Lutfiyyah al-Khateeb and Samira Islam (El-Sanabary, 1993). According to El-Sanabary (1993, p. 1333), Lutfiyyah al-Khateeb studied her nursing diploma in Cairo in 1941. Then she returned to Saudi Arabia and dedicated her life to Saudi women, to their education and to the concept of nursing as a suitable profession. In the 1960's, she won much support for her work and helped establish health institutes (HIs) (El-Sanabary, 1993).

Prior to the 1960's, the Saudi population relied on traditional forms of health care and nursing was practiced within this paradigm (Mufti, 2000). There were no public nursing schools and no women were employed outside the home prior to the

1960s (El-Sanabary, 1993; Mufti, 2000). Traditional nursing practices were used at home and were provided by family members. The practice of midwifery, for example, was carried out by ordinary Saudi women. The first public nursing schools began in the capital city Riyadh in 1958 (Tumulty, 2001a). Even though there were no nursing programmes, many Saudi women were highly skilled midwives. For them, there was no perceived need for formal education. Their skills were obtained by observing and learning from more experienced family members. Since the advent of formal nursing programmes, midwifery and nursing practices have changed significantly in Saudi Arabia.

As has been shown, nursing in Saudi Arabia has a long history and many elements of nursing education, training and other practical aspects are founded in a tradition of care that has developed over time. However, most of these traditional aspects of caring on which the nursing profession of Saudi Arabia was founded, and from which it has adapted, have not yet been analysed. Even though Rufaida helped to establish the professional of nursing, prior to its development in the Western world, her contribution to nursing has been largely ignored. What is critical to our study is that the prophet Mohammed sanctioned and supported her nursing practice. Therefore, the question arises as to why nursing should be considered so undesirable in today's society? In the next section, the current state of the nursing profession in Saudi Arabia is discussed.

2.1.3.2 The Current Situation

Since the establishment of the first education programme for Saudi nurses in 1958, the government has encouraged Saudi nationals to join the nursing programme. However, since the first health care facility was established in Saudi Arabia, nursing positions have largely gone to non-Saudi nurses. Contemporary

nursing care has always relied on expatriate nurses from all over the world, and the

modern nursing programme being implemented in Saudi Arabia is based on a

conceptual model from the Western perspective (Littlewood & Yousuf, 2000). A

decade ago Littlewood and Yousuf (2000, p. 675) claimed, 'there are no nurse

theorists from within Saudi culture'. This is changing, with researchers like Sandra

Lovering and Mustafa Bodrick being two among many who have concentrated in

their PhD studies on nursing theories within the Kingdom, but to date these two

theses are not published. This in itself creates significant issues for Saudi nursing.

Nursing varies from country to country, from culture to culture, as well as

between different types of cultures, such as between Arab and Western, and between

developing and developed nations. Nursing in Saudi Arabia is different to nursing in

other countries because of religious as well as cultural factors. The fact that nursing

is carried out by nurses from many different cultural backgrounds (Almalki et al.,

2011) affects the nursing culture in Saudi Arabia. The expatriates come from many

different countries: Asian nurses usually provide bedside care and management is

often performed by nurses from European countries. Saudi nurses have their Islamic

beliefs and customs that are central to their nursing, which often sets them apart from

other nurses.

Further, Saudis prefer, and even insist on, same gender nursing. Women

caring for male patients and working with male staff is not socially or culturally

acceptable (Al-hmadi, 2002; Gazzaz, 2009). El-Gilany and Al-Wehady (2002)

carried out a study to assess the degree of satisfaction of 233 Saudi female nurses

with their work conditions. They found that the majority of female nurses preferred

not to provide care to male patents.

Saudis—both nurses and patients—do not follow the cultural guidelines of the Western world. This has important implications for nursing, especially when nursing influences are often within a Western framework. Mooij (2009, p. 58) says:

'Some cultures tend to rely on facts, some on ideology or dogma, and others on traditions or emotion. The Saudis seem to be intuitive in approach and avoid persuasion based primarily on empirical reasoning.'

According to Mooij (2009, p. 58), 'Western learning methods are largely based on critical thinking and analysis'. These differences create conflict. Kissell (2009, p. 70) states:

'We should fit our methods of distribution to the meanings of the goods we have in a society to distribute. A resource such as health care that is so intimately tied up to what it means to be human should be available to all.'

Mooij (2009) also speaks of the different ways in which different cultures teach, the different ways of gathering and weighing evidence and of presenting viewpoints and reaching conclusions. For example, according to Mooij, Asian learning systems are based more on initial memorising. Mooij also states there is no single way of logical thinking. The way in which arguments are supported also varies across cultures. These factors contribute to Saudi nurses not having the professional identity that nurses in other countries might have because they are not in control of their knowledge, profession or research. This is both a consequence and a sign of neglect in Saudi nursing.

2.1.3.3 Nursing as a Concept in a Caring Society

The concept of nursing care is traditionally supported by those who consider caring from cultural and religious perspectives (Jackson & Gary, 1991), and nurses are usually perceived as caring people who are responsible for providing nursing care to their society within a cultural context. Moreover, since nursing is about care and caring, nurses often demonstrate a holistic, well-balanced approach to life.

The relationship between nursing knowledge and skills and the capacity of nurses to care has developed nursing into a recognisable career (Barrett, 2006; Harris, 2004; Maas, 2006; Shaw,1993). Caring is a necessary step towards the goals and aims of nursing in a caring society. As a caring science, nursing is a profession consistently contributing to the prevention of poor health practices and the promotion of care for the wellbeing of the community and its members.

The concept of the reflective practitioner was mentioned early in nursing literature (Bowden, 2003; Bulman, 2004; Cowen & Moorhead, 2006b; Leininger, 1992). This discourse describes nurses as thoughtful, reflective practitioners who, as an appropriate and essential part of nursing care and nursing diagnosis, are able to describe and express their emotions about caring for their clients (Benner, Tanner & Chelsa, 1996; Swanson, 1991).

Experts in nursing such as Leininger (1992) and Rassool (2000) recognise that the nursing profession is an essential part of the society from which it has grown. The practice of nursing is based on social contracts that explain professional rights and responsibilities as well as on mechanisms for community accountability (Barrett, 2006; Harris, 2004).

The process of caring for patients and promoting good health are functional activities of the profession. The nursing profession relies on formal education and training involving the arts and science to teach nursing care and the skills related to it (Chinn, 2006; Fawcett, 2010; Johnstone, 2000; Keogh, 1997; Leininger, 1991). To

promote and advance the practical skills and maintenance of health, nurses are becoming increasingly concerned with enhancing their knowledge and developing their skills (Chinn, 2006; Fawcett, 2010; Jeffreys, 2006 Johnstone, 2000).

According to Brink (1994) and Leininger (2002b), transcultural nurse researchers have been able to identify some of the culture-specific meanings, forms and practices related to generic and professional care. 'These care constructs are being used in specific ways to guide professional nursing decisions and actions to provide culturally congruent care' (Leininger 1992, p. 31).

Care is central to nursing and to Islam. Nursing cannot be run like a business, in which profit or expediency is the main aim, and it cannot employ workers who lack a caring approach. Nursing needs to be a well-organised profession, intrinsically concerned with the health and wellbeing of nurses, as well as that of its clients. This means leadership and management in nursing must work in the best interests of nurses. This requires that nurses be helped to effectively carry out their professional tasks.

Leininger (1992) developed and refined qualitative methods to document the epistemic and ontologic realities of nursing at a time that there were virtually no supporters or workers interested in this approach. She attests to the fact that leadership must not only be creative but that it must also be persistent and have a deep commitment and vision for what might be best for nursing, society and humanity. In addition, Leininger (1992, p. 29) states, 'human care has at last become the central focus of nursing knowledge and practice, grounded in the explication of embedded meanings, patterns, and interpretations from both client and nurse perspectives'. However, this is not evident in Saudi Arabia due to the issues raised relating to poor nursing management and education.

2.1.3.4 The Concept of Caring in Islam

The notion of caring in Islam is a central one. However, nursing as a caring profession appears to be at odds with caring within the Saudi culture. Although Western women have made a meaningful contribution to nursing in general, caring from an Islamic perspective is not well acknowledged in the nursing literature. Moreover, the contribution that Western nursing theory has made to the development of the nursing profession in Saudi Arabia has been limited. The theoretical framework that involves caring in nursing education and practice does not engage Saudi nurses. There is no perspective based on Islamic values because the nursing research in this area is limited, however it is growing (Mebrouk, 2008; Rassool, 2000) A significant issue is that much of the research remains unpublished and therefore not readily available.

Nursing is one of the earliest professions in Islam because of its roots in caring (Al-Hetheli, 2008). Muslim women have always been considered as the major and significant contributors in supporting and offering not only physical, but also spiritual care (Haddad, 1984; Hamadan, 2005; Omar & Allen, 1996; Sidani, 2005). The participation of women in nursing can be seen as a reflection of what women can, might or should do in improving and developing their society (Hamadan, 2005; Nightingale, 1859). The image of nursing in Saudi Arabia does not reflect the reality of nursing from an Islamic viewpoint. Instead, it stems from the perception of those who have inaccurate information about what nursing is: for example, both male and female nurses are often perceived as maids or servants.

However, as caring is at the core of Islam (McKennis, 1999; Rassool, 2000; Winter, 2000), Saudi nurses should commit to represent this caring from an Islamic perspective—thereby showing nursing from another viewpoint. Caring from an Islamic point of view is a *responsibility* for Saudis which has to be carried out to a

high standard (Rassool, 2000). Through a phenomenological study, Mebrouk (2008) found that this attitude towards caring and its connection with Islam is central to the practice of Saudi nurses in one of the hospitals in the Eastern region of Saudi Arabia: he argued that caring is closely linked to the Islamic values of the participants.

However, among the Saudi public, there is widespread misunderstanding of the concept of caring in Saudi nursing. In general, Islamic action within the context of health care and nursing practice is inadequately understood (Al-Hetheli, 2008; Rassool, 2000; Winter, 2000). Rassool (2000, p. 1481) states that in Islam:

> 'Caring is expressed on three different levels: intention, thought and action. Underlying the intention and verbal expression of caring is the understanding of what, when, who to care for and why.'

Further, Rassool draws on Salleh (1994) stating:

> 'At the action level is the question of how, and this is related to knowledge, skills and resources (accountability and responsibility are embedded with the process and outcome of caring)' (Rassool, 2000, p. 1481).

In response to this, Rassool stresses the Hadith (narrative) of the Prophet Mohammed (PBUH) that:

> 'Each of you is a guardian and is charged with a responsibility, and each of you shall be held accountable for those who have been placed under your care' (p. 1481).

The lack of an Islamic model of caring affects the performance of Saudi nurses. Further, the teaching of nurses in Saudi Arabia is based on non-Islamic

perspectives. Saudi nurses encounter difficulties relating to the language of the programme of study, which is not related to their intuitional reality, nor to their cultural perspective. Rassool highlights the need for a model of nursing education based on the Islamic perspective on caring. He emphasises that nursing researchers should develop a nursing framework for use in Islamic countries that is applicable to both Muslim and non-Muslim patients. The rationale for the development of a nursing model or models of practice from an Islamic perspective is based on the notion that current models of practice do not consider the holistic needs of Saudi society.

Within the Islamic perspective, the concept of care is regarded as a spiritual domain in which the basic needs of the patients are met according to the Holy Qur'an and the statements (Hadiths or narratives) of the Prophet (PBUH) (Rassool, 2000; Winter, 2000). It is important to explore, for Saudi nurses, the influence of religious background and spirituality on their nursing. This involves investigating issues such as the gender segregation of nurses and patients. Further, Saudi nurses uphold the five pillars of Islam, meaning that they have a need to observe prayer times. This requirement may affect the relationship between the Saudi and expatriate nurses. Currently, because of the employment of many Muslim expatriate nurses, Saudi nurses are able to pray at the required times. However, if this mix changes—such as through the employment of European nurses—conflict may arise at prayer times regarding who will care for patients.

Nursing as a profession emphasises an ethical code (Fawcett, 2010; Johnstone, 2000) and such codes need to be considered for Saudi nurses as well. It is worth analysing how ethical codes match the experience of Saudi nurses. Many Western cultures have a code of Ethics, and example of which is the American

Nurses Association (ANA). Joel's (2006, p. 337) outline of the ANA Code of Ethics

for Nurses with Interpretive Statements is shown in Table 2.1.

Table 2.1

The ANA Code of Ethics for Nurses with Interpretive Statements

Code	Statements
1	The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes or the nature of health problems.
2	The nurse's primary commitment is to the patient(s), whether an individual, family, group or community.
3	The nurse promotes, advocates for and strives to protect the health, safety and the rights of the patient.
4	The nurse is responsible and accountable for individual nursing practices and determines the appropriate delegation of tasks consistent with the nurse's obligation to provide optimum patient care.
5	The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence and to continue personal and professional growth.
6	The nurse participates in establishing, maintaining and improving health care environments and conditions of employment conducive to the provision of quality health care and consistent with the values of the profession, through individual and collective action.
7	The nurse participates in the advancement of the profession through contributions to practice, education, administration and knowledge development.
8	The nurse collaborates with other health professionals and the public in promoting community, national and international efforts to meet health needs.
9	The profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, for maintaining the integrity of the profession and its practice and for shaping social policy.

This Code of Ethics is consistent with the Saudi nurses' experiences of what nursing should be. It is also relevant to Saudi nurses' actions and responsibilities as Muslims, although Muslims are taught the concept of caring from a different viewpoint. Although Saudi nurses have been taught to be Muslims, often they do not understand the concept of caring from an Islamic point of view. All of the points of the ANA Code of Ethics are consistent with Islamic law and this should be practiced by each Muslim. However, it must be noted that unless they are understood, these Codes cannot be implemented. To this end, Saudi nursing structures may help. In the next section, the current structures in Saudi nursing will be discussed.

2.1.3.5 The General Nursing Environment in Saudi Arabia

It is imperative to prepare Saudi nurses who are culturally sensitive and competent. Achieving such an aim must involve the cooperation of nurses in decision making and a stronger relationship between nurses and management. Further, management theory holds that employees are entitled to have a voice in determining some of the conditions affecting their interests in the work environment (Brown & Busman, 2003; Milton, Entrekin & Stening, 1984).

Expatriate nurses have led the way in the development of standards and clinical pathways for nursing in Saudi Arabia. These standards are not consistent across the multicultural workforce (Brown & Busman, 2003). It has been claimed that the multicultural experience associated with working in Saudi Arabia may not be unique to KSA (Brady & Arabi, 2005). However, Saudi Arabia has one of the most pronounced differences in the ratio of native to expatriate nurses.

So far, there has been little research examining the relationship between Saudi and expatriate nurses in the clinical setting. Consequently, many of the difficulties arising from having an expatriate dominated workforce have not been

articulated and remain subjective or anecdotal. Still, researchers argue that many

health care professionals are leaving because of problems in the workplace (Brown

& Busman, 2003; Ray, Turkey & Marino, 2002).

The ethnic mix of the nursing workforce is problematic because nurses come

from different cultural and value systems and have different languages, skill levels

and educational backgrounds. Nurses of diverse cultural and ethnic backgrounds

bring a range of life and learning experiences to the clinical setting (Brown &

Busman, 2003; Luna, 1998). These nurses are usually technically competent.

However, issues occur due to cultural and social backgrounds and language barriers

(Marrone, 1999). According to Brady and Arabi (2005, p. 544):

> 'Health care professionals who have trained in different countries
>
> face the challenge of developing a flexible attitude towards
>
> controversial ethical and legal issues while working abroad or
>
> caring for people at home but from different cultural backgrounds.'

Sebai (1987) argues that, compared to the Saudi worker, the expatriate is

more likely to view themselves as a hired functionary and less likely to take active,

inventive responsibility for their work. In addition, because women in Saudi have

less freedom, many expatriate nurses express dissatisfaction. These problems are

current (Tumulty, 2001a). Some nurses in Saudi Arabia also express dismay at the

amount of responsibility in their jobs. Tumulty states that in some situations, staff

nurses are expected to assume responsibilities, such as of being a head nurse, with no

added training, authority or pay (Tumulty, 2001a), leading to dissatisfaction in the

work environment.

According to Cartwright and Cooper (1993, p. 61), 'one way of examining

the culture of employees is to examine employee satisfaction with organisational

processes'. Bègat, Ellefsen and Severinsson (2005) identify six factors that impact

on nurses' satisfaction with their work environment: job stress and anxiety,

relationships with colleagues, collaboration and good communication, job

motivation, work demands and professional development. Conversely, a Saudi study

of 500 nurses conducted at MOH hospitals in Riyadh by Al-Ahmadi (2002) found

that the most important determinants of job satisfaction were recognition, technical

aspects of supervision, work conditions, utilisation of skills, pay and job

advancement. The results of the study showed that job satisfaction of nurses is

positively correlated with years of experience, but that this satisfaction varies

according to the educational level of nurses (Al-Ahmadi, 2002, 2009). In addition,

cultural and social fulfilment of Saudi nurses was found to have a direct impact on

their job satisfaction (Al-Hosis, 2006; Gazzaz, 2009; Simpson, Butler, Al-Somali &

Courtney, 2006).

Nursing practice in Saudi Arabia has been significantly influenced by

traditional, socio-political and cultural factors, which affect the nurses' view of his or

her profession (Gazzaz, 2009). Any one of these factors can create and increase

problems for Saudi nurses, and the nurses themselves do not have the resources

needed to facilitate cultural change in the workforce. Therefore, in its current state,

the nursing profession is unlikely to provide the prospective or practicing nurse with

job satisfaction (Robinson, Murrells & Clinton, 2006).

Many nurses express dissatisfaction in their workplace and nursing

administrators are usually unable to meet the needs of Saudi nurses (Phillips, 1989;

Tumulty, 2001a). Phillips (1989) and Tumulty (2001a) stressed that there is a great

need for Saudi nationals to become more self-sufficient in the nursing profession

with less reliance on foreign nurses. However, the problems outlined above are only

some of the issues facing Saudi nurses. To establish the foundation for the proposal

of methods by which the situation in the Saudi nursing profession can be improved, it is important to examine not only the structures of the nursing workplace, but also to investigate the subjective issues faced by nurses, such as their perceptions of their needs, career development and the likelihood of future improvements.

2.1.4 Saudi Nursing Issues

Research to date has not examined the nurse's views or their professional reactions to their practice, and researchers need to keep in mind that 'the workplace produces patterns of social inequality' (Costello, 2005, p. 1). The issues related to Saudi nurses are varied. They concern a lack of Saudi nursing research, inadequate education and training of nurses, a lack of cultural understanding and the misinformed attitude of the Saudi population towards nursing (Al-Omar, 2004; Gazzaz, 2009). There is also a lack of suitable managerial systems to deal with these issues (Tumulty, 2001a). Further problems lie with the nursing authorities and nursing frameworks in Saudi Arabia in which the power in nursing rests in foreign hands, rather than with the Saudi Nursing Council. There is a lack of support structures for Saudi nurses and the different nursing authorities are not effectively linked (Simpson, 2002; Tumulty, 2001a). Moreover, Saudi nurses have to deal with issues relating to communication, such as when they are required to read texts not written in their native language, or in their daily duties, in which they must work closely with nurses from a variety of cultures who speak numerous languages.

These are just some of the issues facing Saudi nurses, all of which contribute to the problems in recruitment and retention. The overarching theme linking these various issues is that of neglect. Nurses, their needs and the needs of their patients have been neglected for too long. Now, there is much that needs to be done if the lived experiences of Saudi nurses are to be viewed as worthy of respect in KSA.

However, it is the contention of this paper, that by increasing the standing of the nursing profession in Saudi society, many of the current issues facing Saudi nurses can be resolved.

At the international level, nurses have taken responsibility for their own profession. This responsibility has involved reflection and discussion that has established that only through research can nursing as a profession modernise and share its activities among all nurses (Castles, 1987; Huber, 2006). This cannot occur without knowing and understanding the processes involved in nursing research. Saudi female nurses have graduated from universities, such as King Saud bin Abdulaziz University and King Saud University, for more than a decade – but these nurses are a minority and many do not enter the workforce (Tumulty, 2001a).

Some nursing courses in the institutes and the colleges now include research, however the content is very basic and less advanced than the equivalent in Western university courses. This means graduating nurses generally have a limited understanding of how to utilise research. Compounding this, there are an insufficient number of postgraduate courses, and research training or active nursing research remains minimal in programmes from Saudi universities.

2.1.4.1 The World View of Nursing Education

The main goal and purpose of education in any country stems from the cultural values, beliefs and ideology of its citizens (Wiseman, Sadaawi & Alromi, 2008). If we reflect on the worldview concerning nursing education, there are progressively more insights for turning the challenges of education and practical teaching into opportunities to motivate nurses to take appropriate action (Oermann & Heinrich, 2007).

In the context of Australian health care, learning frameworks suggest a need for evidence-based practice that maintains an ability to reflect on reform (Jones & Hoffiman, 2005). An evidence-based health service such as the one illustrated by Muir-Gray (1997, as cited in Jones & Hoffiman, 2005, p. 4) involves organisations designed with the capability to generate and the flexibility to incorporate evidence, as well as individuals and teams that can find, appraise and use research evidence.

By itself, nursing education is contingent on system reform (Blackmore 1997, p. 447). Hallam (2000) points out that professional nursing has always been torn between striving for status through education and training and trying to achieve it by probing managerial ability through controlling the practical issues in the workforce. Nursing educators emphasise the creation of dynamic, inclusive and challenging learning environments that reflect the purposes of education and meet the need of society by training well-qualified nurses (Pharris, 2009).

The findings of a study carried out by Sonmez and Yildirim (2009) suggest that the most common technique used for nurses for career development is education. The objective goal of postgraduate education in nursing is seen as conveying the competent provision of high skills and improving competency among advanced nurses (Pelletier, Donoghue & Duffield, 2003). When graduate and postgraduate education in nursing is utilised, decision-making skills were found to be highly advanced among nurses (Girot, 2000).

Girot (2000) and Simpson (2002) argue that critical and analytical thinking are a valued aspect of nursing education. When education is undertaken at Master's level, nurses aim to develop critical thinking skills in their practice and facilitate better decision making (Lyneham, 2004). Such education supports their role as advanced nurses, improves patients' health outcomes and develops the capacity of nurses for research (Girot, 2000; Simpson, 2002).

An early study found personal growth, professional growth and professional socialisation were the most important motivators to pursue nursing education, especially at Master's level (Watson & Wells, 1987). The opportunities offered by access to higher education and career improvement were claimed to increase not only nurses' motivation (Thurber, 1988), but also their control over the development of their organisation (Harvey & Brown, 2001). Pelletier, Donoghue, Duffield, Adams and Brown (1998) found that nurses who had undertaken higher degrees in nursing had better job opportunities, more satisfying personal situations, job satisfaction and increased professional status.

Further, nursing education stimulates reflection and discourse. Nursing educators currently involved in the nursing profession suggest that discourse is challenging the concept of the profession. They argue that the opportunity for general discourse in education has played a major role in furthering the recognition of nurses (Castle, 1987; Hallam, 2000; Heath, 2002). Hallam (2000) points out that nursing education leads to nursing voices being heard and recognised through research publications. Education and discourse also lead to discussion in the media. According to Cowen and Moorhead (2006a), on a worldwide scale, the increasing dichotomy between nursing education and nursing practice is narrowing. As nursing moves towards more independence, governance models for nursing centres and community-based practices are beginning to emerge (Cowen & Moorhead, 2006a).

One of the hallmarks of progress is being able to govern one's domain (Cowen & Moorhead, 2006b). Kossman (2009, p. 55) states:

> 'Modelling nursing education's values and creating a welcoming
> environment for all nursing students can be part of the solution to
> today's nursing shortage and lack of diversity.'

According to Oermann and Heinrich (2007), nursing educators face many challenges, but they must persevere. Kossman points out that the 'failure to do so [persevere] … leads to creation of barriers to students' education and increases their sense of isolation and struggle' (2009, p. 55). An increase in challenges prevents the nursing profession from becoming more effective, and limits students' graduation rates.

2.1.4.2 Nursing Education in Saudi Arabia

The importance of education has not being embraced by Saudi nurses or authorities. This is evident in the previously stated fact that the only male courses of study available are at the diploma level in the health colleges and health institutes and that there are no postgraduate courses for men available. For women there are few degree and postgraduate courses available and it is often difficult for women to travel to these centres. In addition, no undergraduate courses are accredited to meet minimum standards. The increased demand for high educational standards and the accompanying skills that are required are a priority for nursing practice. Formal education based on practical issues is one of the most important needs in the development of the nursing profession in Saudi Arabia. The emphases on primary health care, new models of collaborative practice, the shift from institutional to community care, new developments in technology and the supply and demand for various health providers with particular skills and ideas, are problems for nursing educators and researchers (Washington, 2006). These issues are rarely even considered in Saudi Arabia, where, for example, there are a few community nurses in the private sector who visit patients at home.

The education and preparation of nurses has improved considerably internationally, but the pace of such improvements in Saudi Arabia is slow. Many

authors indicate inadequate professional development of Saudi nurses as a result of ineffective nursing education, inadequate training of nurses in the workforce and a lack of communication, coupled with a lack of resources (Aboul-Enien, 2002; Al-Hetheli, 2006; Al-Hosis, 2010; Altallal, 2006; Tumulty, 2001a).

There is a gender bias in nursing education in Saudi Arabia. Males, for example, upon completion of basic nursing education usually want to pursue further study. However, due to the limited opportunities in Saudi Arabia, they find it difficult. Male nurses especially usually leave the country to gain further formal education.

Castles (1987) suggests that nursing as a profession must be based on extensive education and specialised training to teach relevant competencies. These competencies, or common characteristics, are considered to be held by many professionals in nursing (Andrist, Nichloas and Wolf, 2006; Castles, 1987; Keogh, 1997; Oweis, 2005). These characteristics, according to Castles (1987, p. 4) are:

- The expertise of the professional nurse depends on an extensive body of theoretical knowledge.

- The professional is devoted to service.

- A profession has a collegial organisation rather than a bureaucratic one.

- Professionals have both licence and authorisation.

The nursing profession in Saudi Arabia is lacking these features. Only with a significant increase in skills and knowledge can nurses be competent in the workplace. The characteristics the nursing profession demands, such as a high level of intellectual functioning, a well-organised body of knowledge and a strong professional organisation, are supported when nurses increase their qualifications. With improved skills, nurses can become more responsible and accountable, which

increases their specialised body of nursing knowledge and their competency (Oweis, 2005; Keogh, 1997).

Upon graduation, Saudi nurses experience various difficulties in their practice that cause a general lack of expectation in the services provided by them. Consequently, native Saudis are less likely to seek entry, comply with and/or accept work assignments. This is a system failure. However, the Saudi attitude to nursing education is also responsible.

Nursing education in Saudi Arabia has gone through many different phases. Currently, nursing education is managed by authorities who do not have good relations with nursing authorities. The MOH began a nursing education programme in 1958 in Riyadh. This was a one year programme for male Saudis who completed elementary school (Tumulty, 2001a) (at approximately 12 years of age). The nursing programme was upgraded to a three year programme for both males and females through HIs in 1960. However, the requirement was the completion of middle high school (at approximately 15 years of age). It should be noted that secondary education is not compulsory.

The first HI programme for females started in the 1960s. On completion of this programme, students were awarded a diploma in nursing that was claimed to be equivalent to that of a licenced practical nurse in the US (Jackson & Gary, 1991; Miller-Rosser et al., 2006; Phillip, 1989). This equivalence is not the reality. Nurses who graduated lacked most of the necessary skills and knowledge that nurses are required to have if they are to be licenced. These qualifications are not what Saudi nurses want and they reflect a poor understanding of nurses' needs.

The government realised that the need for nurses in Saudi Arabia exceeded the supply of Saudi nurses. In 1992, this resulted in health colleges, under the supervision of the MOH, being established to meet the demand for qualified health

professionals. Currently, there are 16 HIs—two for males and 14 for females—while the number of health colleges is 30—15 for males and 15 for females (MOH, 2008). Under the Ministry of Higher Education, two colleges of female nursing were established in 1976, one at King Saud University in Riyadh and the other one at King Abdul-Aziz University in Jeddah, both offering a Bachelor of Science in Nursing (BSN) (Tumulty, 2001a).

Postgraduate courses were established for female nurses at the King Saud and King Abdul-Aziz Universities in 1987 with a Master of Science in Nursing. A PhD programme was started at these institutions in 1994 with the cooperation of British Universities. The rationale for this was to facilitate career advancement for women who could not study abroad. A scholarship programme was established in 1996 to train Saudi nurse leaders and educators through studying abroad (Abu-Zinadah, 2006). Still, the number of graduates is extremely low.

2.1.5 Cultural, Social and Religious Influences on Saudi Nurses

Saudi Arabia is a young nation with an ancient history. It is one of the most conservative traditional societies in the Middle East (Long, 2005). According to Long (2005), Saudi culture is in constant flux and the culture gap between the West and Saudi Islamic culture is wide. The Saudi people are a proud race with a closed society, yet they play an important role in current world affairs. Saudi culture has developed through age-old interactions between the Arabian nomad and their cruel environment. Saudi Arabia is the birthplace of Islam and the basic Islamic values of Saudi culture have remained to this day (Al-Shahri, 2002; Long, 2005). The religion of Islam is the main, though not the only, factor that forms and shapes the Saudi culture (Al-Shahri, 2002; Littlewood & Yousuf, 2000).

2.1.5.1 Cultural Influences

If all the expatriates left Saudi Arabia, the country would not manage. This is not only because there would not be enough workers—in nursing among other industries—but also because, I believe, Saudis have become lazy. This is reflected in their acceptance of low education standards, a general lack of interest among Saudi people in improving their educational qualifications and in the fact that the Saudi culture considers it normal to have the country filled with expatriates.

The Muslim and Arab culture of Saudi Arabia is one in which traditional values and ideas are adapted into legal prohibitions relating to personal, political, economic and legal aspects of society for both Muslims and non-Muslims alike (Al-Shahri, 2002; Gallagher & Searle, 1985; Littlewood & Yousuf, 2000). Alcohol is prohibited, for example, as are pork products; and popular forms of media entertainment, when not banned, are permitted only under tight controls. Arabic is the official language of Saudi Arabia, but English is widely spoken and it is a compulsory second language in schools.

Saudi religion and culture are intertwined. Muslims are obligated to pray five times a day and, during the holy month of Ramadan, all Muslims fast from dawn to dusk and are only permitted to work six hours per day. Expatriates are not required to fast but they cannot eat, drink or smoke in public during the holy month of Ramadan.

The shortage of Saudi nurses is directly related to sociocultural factors that influence the prevailing negative images and perceived low status of nursing (Gazzaz, 2009). One of the issues discussed by Washington (2006, p. 49) is the impact of culture on nursing. In Saudi Arabia, social behaviour and cultural matters are grounded in Saudi personal activity, which is dependent upon the identity of and the uniqueness of a Muslim person in society. It is connected to our religious faith and our perceptions of the way our culture is supposed to be. Washington (2006)

argues that cultural identity influences all of the domains of nursing including personal, health and the environment. Leininger (2002a, p. 6) writes:

> 'For human care to be meaningful and therapeutic, professional knowledge needs to fit with the cultural values, beliefs, and expectations of clients. If professional knowledge and skills fail to fit the client's values and lifestyles, one can anticipate that the client will be uncooperative, noncompliant, and dissatisfied with nursing efforts.'

Saudi nurses need to be aware of cultural issues. According to Johnstone (2000), it is vital that nurses and allied health care professionals understand the nature of culture. Further, they need to see the link between culture and ethics, which is an integral part of nursing knowledge. He claims that, 'what particularly needs to be understood is that culture exists logically prior to ethics, not the other way around' (Johnstone, 2000, p. 66).

Saudi nurses need to know what constitutes appropriate and ethical care of their clients, according to cultural values. Nursing educators and researchers need to consider cultural issues pertaining to the training of and professional practice of nurses (Leininger, 1991; Littlewood & Yousuf, 2000; Krentzman & Townsend, 2008). There are many situations that reinforce this view. People in end-of-life situations, for example, frequently express belief that God has priority over life and can do more for patients than health care professionals can (Al-Shahri, 2002). Nurses need to be aware of such things if they are to be able to care as well as possible for their patients.

We all have beliefs that affect who we are and how we perform in the workplace. Krentzman and Townsend (2008) point out that our beliefs include

awareness of our history, values, limitations and biases, as well as respect and sensitivity to differences. Therefore, necessary knowledge includes an understanding of socio-political history, the role of cultural intolerance, specific details about the group with whom one is working and institutional barriers. Key skills of nurses should include the ability to send and receive information verbally and nonverbally, to understand and be understood in a variety of cultural styles (Crystal, 2008; Knowles, 1990; Krentzman & Townsend, 2008).

An individual's environment and culture are related to the uniqueness of their perception; the way they think and the way they understand things in their world depends upon their awareness of their environments (Gray, 2002; Jagtenberg & D'Alton, 1989). A nurse's cultural background is one of the most important factors influencing others' perception of the nursing profession. Pharris (2009) indicates the critical need for nursing educational systems to produce more culturally diverse nurses. They emphasise the need for nursing educators to critique and redesign their curricular, pedagogical and structural systems to accommodate this need for cultural inclusion within nursing education, ensuring a more culturally inclusive educational environment. The environment into which Saudi nurses must fit is one in which Muslim/Arab culture dominates. Unfortunately, within this environment, there is currently little room for respect for Saudi nurses.

2.1.5.2 Social Influences

The family is the basis of Saudi social structure and Saudis take their responsibilities to their family very seriously. Families provide security and assistance when needed and the extended family tends to engage in nepotism (or *wasta*: الأقارب محاباة)—employing family members one knows and trusts.

As with culture, the social influences in Saudi society are intrinsically connected to Islam. Regarding nursing, the views of society further reduce the appeal of nursing. Saudi society has frowned upon some professions, and nursing is one of these. To change this view, it will be necessary to explore Muslim ideas and show that nursing is a noble profession, rather than a servant- or slave-like profession. Social influences on Saudi nurses concern the social fabric of the country and the expectations society places on both men and women. In exploring these, an understanding of religious influences is essential.

2.1.5.3 Religious Influences

Islam comprises a strong element of justice. Muslims believe that the purpose of life involves serving and doing good and that there is no religious meaning in life unless justice lasts forever (Khadduri, 1984). It is Islamic teaching that needs to be explored to understand Saudi society and the many issues facing Saudi nurses. Recent research indicates the relationship between religion and the health of individuals and communities can be seen in the social, behavioural and health sciences (Chatters, 2000).

Gender segregation is one such issue that needs to be treated as sensitive. As discussed in the introduction, Muslim scholars, such as Ahmad Mohammed Jamal (1986), another staunch opponent of women's work, have written extensively about the destructive effects of women's work, especially in situations in which men and women work together. Jamal (1986, as cited in El-Sanabary, 2003, p. 266) states that Saudi women 'should work only with people of the same gender'. He also says that the role of Saudi women should be 'to inspire other women in conforming to Saudi moral values'.

El-Sanabary (2003, p. 265) states that Mohammed Ali El-Bar was one who believed that women should not work outside of their home. The author claims that El-Bar, in 1987, suggested that 'unavoidable moral corruption' resulted when genders intermingled. Jamal had similar opinions, suggesting that 'women be able to work as long as there was no intermingling of the genders' (p. 266). El-Sanabary (2003, p. 265) points out that Jamal argued that 'Saudi women, by virtue of their Arab Islamic society, do not need to compete with men for jobs except that are fit for them'. Things are changing now, but slowly. Health care, like education, is considered an occupation suitable to the nature of Saudi women. Saudi women are also employed as physicians, health care administrators, medical technicians and in nursing (Doumato, 1999), but this is rare.

How do Saudi women (and Saudi men) cope with these limitations? Those interested in nursing often have some understanding of the history of nursing and are aware that nursing is a noble, sacrificial and important profession. Comments like Jamal's are not based on the Holy Qur'an. Instead of projecting a negative viewpoint, he should emphasise views about the necessary importance of nursing, the benefits of Saudisation and the need to promote nursing culturally as a worthwhile and rewarding profession for both sexes.

There is the expectation in the Saudi culture that women should be in the home in the evening because of their caring role in their families. Contemporary conservative Muslim writers have produced publications extolling the virtues of women who choose to remain at home. Such publications include: 'Remain in Your Place and Be Grateful', 'Women's Work in the Balance', 'The March of Saudi Women, To Where?' (El-Sanabary, 2003, p. 265). Such publications argue that the breakdown of Saudi family values is directly related to women's employment outside the home (El-Sanabary, 2003; Miller-Rosser et al., 2006). Yet among these

writers are scholars that do endorse nursing, alongside teaching, medicine and social work, as religiously and culturally suitable occupations for Saudi females, 'thus creating conflict in their message' (Miller-Rosser et al., 2006, p. 5).

There is also the constant concern that Saudi nurses are not as prominent in their profession as expatriate nurses or as well paid as their counterparts in state hospitals. Changes are taking place, but not quickly. Saudi nurses have no incentive to break from religious expectations and cultural norms, such as working during the night, if the pay rate is not high enough to attract them. Further, the trained Saudi nurses who are working in other fields of employment have little to attract them back to nursing. The urgent need to prepare Saudi nurses to become culturally sensitive and competent is a growing professional challenge (Al-Shahri, 2002; Jeffreys, 2006), and it needs to be addressed by looking at communication and cooperation in the Saudi nursing profession. This professional challenge could also be addressed by taking the matter to Muslim religious authorities, who, I believe, would find that nursing as a profession has been totally misrepresented. Muslim scholars, if consulted, will need to look at this, as the Muslim influence on all aspects of society is so significant that it cannot be ignored, and must be understood fully.

2.1.6 Nursing Authorities and Frameworks

The Saudi health education system is lacking a theoretical base. As indicated earlier, the theory that the nursing profession in Saudi Arabia requires has not yet been established from within Saudi culture (Littlewood & Yousuf, 2000). This can be seen especially in nursing education, in which the nursing programmes do not consider the concept of practice as an educational experience for Saudi nurses. It is a necessary element of education in that it provides nurses with enough information in

a practical form to encourage some understanding of the concepts of culture and scientific inquiry (Castles, 1987).

Authorities do accept the responsibility of establishing programmes and implementing them in nursing education and practice. However, will these programmes be appropriate? Will they improve the situation? It is important that we consider all factors affecting nurses, such as cross-cultural, cultural and environmental concerns and how nurses themselves feel about their experiences. According to Tumulty (2001a) some important problems of nurses relate to the extent to which nurses engage in non-nursing activities.

Many nursing experts state that advances in nursing practice will only occur as a result of theory and research (Castles, 1987). If nursing authorities in Saudi Arabia are not aware of the results of nursing research, because they do not read research journals, or because they do not understand the relationship of theory and research to nursing practice, nursing knowledge will not increase and nursing practice will not be improved (Avallone & Gibbon, 1998; Castles, 1987; Fawcett, 2010; Goodson, 2003; Jeffreys, 2006). The practice of nursing is based on theory and research, but the new knowledge that is discovered with creativity and skill is useful only if it is used by nursing management and authorities. It is not enough that research produces new knowledge so that it simply exists; it must be tested in practice. If this testing is not performed, specifically in the Saudi context by Saudi nurse researchers or experts, then the new knowledge cannot advance either the science or the practice of nursing in Saudi Arabia.

There is also a lack of secondary nursing resources such as Saudi nursing books and journals for nursing. This lack of resources compromises the Saudi nurse's abilities to stay abreast of new knowledge and technical advances in nursing and health care (Tumulty, 2001a). The lack of resources also causes difficulties for

nursing research. For example, it is difficult to know the number of nurses working outside nursing. The MOH does provide funding for nursing research, but without advanced education, library resources and the ability to move about freely, the general conditions are not conducive to knowledge development (Tumulty, 2001a). Further, Tumulty points out that more studies are needed in which researchers describe their situation and document the outcomes of nursing care provided to the people of Saudi Arabia.

The profession of nursing in Saudi Arabia has continually been dependent on non-Saudi nurses since the establishment of the first hospital and the nursing education system has failed to adequately qualify native nurses. Nurse training programmes have been funded since at least 1979, However, until recently most nurses have come from foreign countries because of the social stigma nursing carries for women (Doumato, 1999, p. 570). According to Doumato (1999), anecdotal evidence suggests that only about 10 per cent of nurses in KSA are Saudi nationals. However, Doumato conducted interviews at the National Guard Hospital in Riyadh in May of 1996 and was told that there were no Saudi nurses at all employed at that hospital. Native nurses are needed now more than ever. However, currently, according to Tumulty (2001a), Saudi nurses are already struggling to meet the needs of a growing population.

2.1.7 Conclusion

This chapter has offered a theoretical perspective on the concept of nursing as a profession. Transcultural nursing knowledge has been examined as it relates to professional identity and the phenomena that need to be addressed by this research. The ways in which nursing research have been introduced has also been discussed and the development of the nursing profession in Saudi Arabia, and the history

behind this development, has been highlighted to show how nursing has emerged as a discipline throughout the history of Islam.

A historical perspective of influences, such as Al-Asalmiya's legacy (as the first Muslim nurse), Nightingale's hierarchical structures and her view concerning what nurses ought to do and the perceived image of nursing as women's work, has been presented to demonstrate how these themes persist and impact upon the Saudi nursing identity.

The current situation of Saudi nurses, as reported in the literature, has been examined to show how nursing in Saudi Arabia is different from nursing in other countries. However, the lack of Saudi nursing research, inadequate education and training of nurses, a lack of cultural understanding, a misinformed attitude of the general population towards nursing and, finally, the lack of suitable managerial systems to deal with these issues, are commonly reported in Saudi nursing literature. These are critical issues. They throw light not only on how Saudi culture affects nurses, but also on how the culture of nursing organisations affects nursing for Saudi nurses.

What still needs to be explored in this research is the impact of current nursing practice in Saudi Arabia on individual nurses. It is the aim of this research to uncover the experience of being a Saudi nurse and uncover the needs Saudi nurses have, based on their understandings of their development and practice as nurses. Consequently, phenomenology has been chosen as the methodology for use in the research because the approach focuses on the lived experiences of nurses and the meaning of these experiences.

It will be further argued that phenomenology as a methodology will enhance understanding of the meaning Saudi nurses assign to their experience of being nurses. The next chapter presents the philosophical framework underpinning this

research. Given that at this point the experiences of the nurses are unknown, further

exploration of the literature will be left until Chapter 7, when it can be discussed in

view of the findings.

Chapter 3: Methodology

'Methodology refers to the philosophical framework, the fundamental assumptions and characteristics of a human science perspective … methodology is the theory behind the method, including the study of what method one should follow and why' (van Manen, 1990, pp. 27–28).

3.1 Introduction

The methodology is the philosophical orientation, or the philosophical assumptions, behind the main goal of the research (Byrne, 2001a; van Manen, 1990). The methodology in this research must emphasise a human caring perspective and generate a method of inquiry that recognises cultural influences, as well as caring patterns and behaviours. It must be capable of indicating the connection between philosophical assumptions, the social reality and the true nature of knowledge that exists in society.

Valid critical analysis in this research requires that the content of the lived experience in which the phenomena of interest is found can be conceived and understood (Husserl, 1913; van Manen, 1990). To achieve this aim, the methodology needs to be systematic and objective (Tilley, 2004), but also involve a close connection between the knower and the known. However, the conservative approach of scientists often ignores the meaning of experience and intuition and of the unity of the subjective and objective realms of the aesthetic experience (Russell, 1946; Smith, 2007; Watson & Smith, 2002).

In Saudi Arabia, finding a methodology that is both compatible with and sensitive to the cultural and religious beliefs of the Saudi nation is critical. Within

the Saudi nursing workforce, little is known about the cultural experiences of Saudi nurses, male or female. The little research that has been undertaken in Saudi Arabia does identify several issues associated with Saudi nurses. These issues have led this research to focus on the experiences of being a Saudi nurse, and on the issues associated with their profession. However, it is important to examine not only the objective professional issues of nurses but also subjective aspects, such as the likely future directions and goals of Saudi nurses. The issues relating to methodological theory, and the need for qualitative methods in this research, is also explained, and the primary kind of qualitative research that is relevant for this research— phenomenology—is also considered in this Chapter. Husserlian phenomenology, as the methodology used in this research, is defined and discussed. Finally, the chapter highlights the appropriateness of phenomenology as a research methodology for the Saudi culture based on the Law of Islam.

3.2 Factors That Have Influenced the Choice of Methodology

3.2.1 Understanding Being a Saudi Nurse

Many factors have influenced the choice of methodology. One such factor is the need to understand what it is like to be a Saudi nurse. In Saudi Arabia, the appearance of nursing—its image—does not reflect the reality of nursing. This research aims to describe the experiences of Saudi nurses and to understand the meaning of being a Saudi nurse. As stated earlier, no research has specifically focused on the experiences of being a Saudi nurse and examined their perspectives and perceptions analysed from the perspective of a Saudi researcher. Nursing, as a caring profession, needs to be considerate of nurses' experiences and the particular situations they encounter (Byrne, 2001a; Madjar & Walton, 1999). It is important to

note that each individual's experiences are unique (van Manen, 1990). Therefore, Saudi nurses' perceptions as they experience all aspects of their practice are a precious source of information.

This research intends to uncover the hidden aspects of the reality of being a Saudi nurse and how this reality affects the nurse. Understanding these experiences leads to an understanding of the essence of the meaning of being a Saudi nurse. The Saudi nurses' lived experience is fundamentally important, not just because it involves a personal perception of objective reality, but because the lived experience is itself reality (Porter, 1996).

Nurses' stories help create nursing knowledge; sharing their experiences as stories, they learn lessons and create strategies for being nurses (Madjar & Walton, 1999). In the words of Lawler (1998, p. 107), 'Nurses bring to their research their experiences from how they have come to know the world from their practice, as well as from their own lives'. By allowing nurses to tell stories, the reality of their lived experiences is exposed and the lived experiences of being Saudi nurses are uncovered.

3.2.2 Nursing as a Caring Practice in a Needy Society

Another factor that has influenced the choice of methodology is the aspect of care in nursing (see Sections 2.1.3.3 & 2.1.3.4). As caring is integral to nursing, it is difficult to be a nurse without being caring. As carers, nurses present a humanistic discipline, with the capacity to shape their own lives as well as the surrounding world by means of their caring.

As seen in the previous chapter, nursing has a long history in Islam as well as in other cultures and caring is very important in Islam, being initially developed through religious perspectives, then further established through the prevalent

philosophical assumptions of Western philosophy, including those implemented through Nightingale's principle of nursing.

It has been argued that nursing models of care practiced within the framework of the nursing profession are inappropriate for meeting the holistic needs of Muslim patients in Islamic and non-Islamic countries. Caring in Islam is much the same as caring in other cultures, but based on personal observation during my practice in Australia, nursing in that country reflects my real understanding of the term 'care'.

However, in Islam it is the intention, rather than the act of caring itself, which is most important. Much thought is given to how the concept of care is transmitted to knowledge, skills and resources, and where responsibility rooted in the process of intention is manifested in actions of care (Rassool, 2000). One of the most serious pathological phenomena in the lives of Saudi nurses involves a perceived gap between internal facts and external accomplishments: between the rule and the idea in nursing practice. It is this gap that needs to be bridged.

Caring is central to Islam. The act of an individual Muslim must be understood as intended as an act of care and our actions are required to be good, just and kind. If our actions are to be 'proper', from a Muslim point of view, then they need to stem from legitimate, kind intent. If not, they will be of no benefit to anyone. However, any benefit must be for the sake of God, according to the principles of Islam in which Muslims believe. This is relevant to the phenomenological perspective, as the core of phenomenology is intentionality (Husserl, 1931). In nursing, the reality of caring cannot be understood without considering the context in which it is experienced. If we take the concept of care out of the context in which it occurs, we only see the appearances of caring.

3.2.3 Understanding and Exploring the Needs of Saudi Nurses

For so long Saudi nurses have struggled to understand what a nursing profession might be, whether it is a concept that includes the rules of science, or whether it is an art involving care and intuition, especially designed for the practicalities of nursing. Authorities within the nursing profession in Saudi Arabia are perceived as lacking insight into how the concept of caring relates to Saudi society. It would seem that long-term reliance on nurses from other countries conceals the reality of Saudi nurses.

Saudi nurses have many needs, many areas of concern and many questions. Currently, the reality of being a Saudi nurse is not being considered from an Islamic perspective and this affects Saudi nurses. Few Saudis understand that nursing as a profession is suitable for both males and females in Saudi Arabia and that it is a Holy profession in Islam.

Further, in Saudi Arabia, it is actually necessary for both genders to be involved in nursing. It is important that we, as Saudi nurses, are concerned about our profession and that we see what others do and how it is relevant to the concept of care in Islam. Only this will lead to greater clarity when it comes to the unique contribution of nursing to Saudi Arabia.

3.3 Methodological Theory

'The more secure the scientists are in their methodological position, the more respect they usually have for intuition' (Holt, 1967, as cited in Valentine, 1992, p. 201).

3.3.1 The Scientific Approach

Scholars argue that human behaviour can be examined using the scientific approach and that in doing so it is important to think of the application of inductive and deductive reasoning. These processes of thought are considered suitable as tools for examining human activities (Potter, 1996; Russell, 1988). Science proceeds by accumulating observations, which are generalised by inductive processes to form laws. Such methods were thought to be objective and reliable (Russell, 1946; Valentine, 1992). Some philosophers claim that reality consists of nothing but minds and their ideas (Russell, 1988), but philosophers generally insist that the nature of people (their essences) can be explored by science and that since the subject matter of science is exclusively physical, the mind must also be physical (Dupre, 2007).

Science is known to be intrinsically associated with objective truth and rigid systematic methods (Anastas, 1999; Carr, 1961; Davies, 1992). In a general evaluation of the sciences, philosophers' concerns are not with the scientific character of the sciences, but rather with what science in general has meant and can mean for human existence. The primary aim of objective science is not only to generate knowledge of the world, but also to elucidate and predict future phenomena and actions on the basis of that knowledge. Tilley (2004, p. 1) points out that 'science is a process of acquiring knowledge and a means of trying to understand reality and reveal the truth'.

Yet within each culture, different visions manifest different methodological approaches to science. Every culture has its conception of what people believe and how they should behave. An understanding of the common conventions of a culture is known as 'common sense'. Understanding the common sense in a culture can only come from understanding what occurs in the minds of people.

3.3.2 Positivism and Empiricism

Traditional research is based on the positivist view of science which holds that the scientific method is the best approach to uncovering the processes by which both physical and human events occur (Bowling, 2002). According to Anastas (1999, p. 5) 'scientific methods play a significant role in discovering the reality of the common errors of thinking that human beings are prone to'. Positivism is about objective truth and a structured approach to the measurement of phenomena. Positivists believe knowledge requires a direct insight or an expression, for which our sense of reason is necessary (Mautner, 2005; Russell, 1988). Conversely, empiricism refers to the traditional belief that all human knowledge and thought ultimately derives from sensory experience (such as, vision, hearing, touch) (Gray, 2002; Husserl, 1970a; Russell, 1988; Valentine, 1992).

Before the seventeenth century, logical positivism (the idea that observational evidence is indispensable for knowledge of the world, combined with the idea that our knowledge includes a component that is not derived from observation) often provided the basis for an individual's understanding of the world in which they lived. Carr (1961) points out that science at the end of the eighteenth century contributed admirably to an individual's knowledge of the natural world, their knowledge of their own physical attributes and their understanding of the nature of being.

As time passed and the method that had been used to study the world of nature was applied in the social sciences to study human affairs (Bowling, 2002; Carr, 1961; Holloway & Wheeler, 2002), changes began to occur. Researchers continued to describe the relationship between phenomena in a quantitative manner. However, as the social sciences developed, researchers were also required to establish qualitative descriptions to express the behaviour of and the relationships

between phenomena. This was done 'through the symbols of languages' (Urbach, 1987, p. 27).

3.3.3 Epistemology and Ontology

As in any system of investigation, epistemology (theory of knowledge) is one of the main parts of the research methodology (Tilley, 2004). The word 'epistemology' combines two Greek terms: *episteme* (knowledge and science) and *logos* (theory) (Dupre, 2007). Epistemology is the branch of philosophy concerned with the nature of knowledge. It addresses the questions: What is knowledge? How is knowledge acquired? What do people know? How do we know what we know? And, what is being? (Ray, 1994). These questions demand universal reflection and answers based on rational insight (Husserl, 1954). Answers and assumptions in relation to these questions determine underlying aims of research, the directions it takes and the methods used. Therefore, epistemological questions lie at the base of all research methods.

Ontology, on the other hand, is a branch of philosophy that deals with questions about what entities exist and how they can be grouped (Smith, 2007). It is about things (forms), people, groups and individuals. Porter (1996) concludes that the basic argument of the ontological question is that social reality only exists as meaningful social interaction between individuals. This basic argument is relevant to this research, which is concerned with social realities. Social realities exist in all cultures and their characteristics vary accordingly. It is obvious that social realities have been influenced by culture and language (Lawler, 1989; Ray, 1994). According to Ricoeur (1986, p. 15), 'it is language that is the primary condition of all human experience'. Further, common phenomena can be understood with shared assumptions among groups within a community.

Epistemology and ontology go well together and must be understood together to understand the methodology needed for this research. Epistemology is about the nature of knowledge and ontology is about the meaning of people and how they group together—epistemology is about 'why' and ontology is about 'how' nurses think individually and as a group. However, philosophy in science also seeks to go beyond the meaning of being, to the relationship between the one who seeks to know and the content to be known (Roger, 2008; Valentine, 1992). There is the knower (the researcher) and the object of the research—these are two separate entities (Potter, 1996; Smith, 2007) and they interact and have a dependency relationship with each other.

3.3.4 Science and Religion and the Lived Experience

'If philosophy is taken to be a pure disinterested search for

knowledge it is understood not to have an ulterior purpose, but to

be a quest undertaken for its own sake (Mautner, 2005, p. 466).'

Science as we know it in Islam has been fully capable of establishing truth in accordance with the law of Islam (Al-Karasneh & Saleh, 2010; Inati, 1984, 1996). The history of Islam reveals that there was a dynamic period of discovery and innovation in all fields of knowledge. According to Abbas and Al-Owaihan (2008), work and creativity were honoured in all their forms. In the seventh century (622 AD) the Arabs were inspired by their Islamic religion, brought by the revolution of the Holy Qur'an by the Prophet Mohammed (PBOH): 'Quranic principles and prophetic prescriptions [which] served as guides for Muslims in conducting their business and family affairs' (Abbas & Al-Owaihan, 2008, p. 7).

The Prophet of Islam (PBUH) stated, 'Seeking knowledge is a duty upon every Muslim'. In Islam, philosophers and theologians have contributed to the

progress of knowledge, their concepts about the natural world have developed a sense of responsibility to control it through spiritual and intellectual endeavours that reflected their physical and natural needs in the universe (Abbas & Al-Owaihan, 2008; Russell, 1946; Spade, 2004).

As in other societies, Muslim philosophers attempted to understand reality and appearance and the logic of the philosophy of science, following the arguments of Greek philosophers such as Plato and Aristotle. The assumptions and ideas of the Greeks had a great influence on these philosophers (Inati, 1984; Mahdi, 1970). Muslim philosophers embraced philosophical ideas of truth and competed with each other to modify the Greek philosophers' assumptions and apply their theories in accordance with Muslim beliefs (Inati, 1996; Leaman, 1997, 1998).

However, the question of the compatibility of Islam and philosophy had not yet been resolved. It has been argued that scholars of Kalam (Islamic speculative theology) have opposed Islamic philosophy, claiming that it was merely pagan philosophy. For this reason, most Muslim scholars avoid the term 'philosophy'. They disapprove of philosophy and its relation to science and reject the idea that it could be relevant to life in the Muslim world (Nasr, 1992). Al-Ghazali (1055–1111), the eleventh century theologian argued in his book '*Tahafut Al-Falasifah*' (Incoherence of the Philosophers) that philosophy should not be applied to religious matters and that the Greek philosophers should be ignored because of their pagan origins (Al-Ghazali, 1963, 1997). However, Averroes (Ibn Rushd) (1126–1198) rejected this belief in his book '*The Incoherence of the Incoherence*' (Tahafut al-Tahafut) and aimed to rehabilitate Muslim philosophy and re-establish a link to the ancient philosophers (Ibn Rushd, 1978). According to Averroes, the Qur'an directs us to reflect and think. Therefore, he argued, we should also be prepared to turn to the work of those who have thought philosophically, regardless of whether they

share the same religion. Averroes insisted that, where ancient philosophers such as Aristotle have shown something to be true, we should accept that it is true, indeed:

> 'All that is wanted in an inquiry into philosophical reasoning has already been perfectly examined by the ancients. All that is required of us is that we should go back to their books and see what they have said in this connection. If all that they say be true, we should accept it and if there be something wrong, we should be warned by it' (Law, 2007, p. 41).

In an Islamic context, theories provide a useful framework through which to reflect on the basic concepts of the cultural and social environments. By using such a framework, this research will reflect the experiences of being a Saudi nurse and help integrate the findings into Saudi Arabian culture.

Nursing in Saudi Arabia, has not been held in high esteem. Its theoretical and practical assumptions have not matched its primary goal as a caring profession. Islam asks us to observe, think and reflect. In Islam, the importance of knowledge is emphasised; we have been told to travel to see, learn, explore and discover things about our history and the history of others. Philosophers and scholars in many cultures agree that most of what we know comes from what we experience and that we can only benefit from what we experience of the life-world. It may be good to have religious beliefs or a vigorous understanding of the scientific method, but there is no substitute for personal experience. Experience and a broad and detailed understanding of Saudi nurses' personal experiences is essential in this research.

Husserl (1917), the founder of phenomenology, explained that natural objects must be experienced before any theorising about them can occur:

'Experiencing is consciousness that intuited something and values

it to be actuality, experiencing is intrinsically characterised as

consciousness of the natural object in question and of it as the

original; there is consciousness of the original as being there "in

person"' (Husserl, 1917, p. 2).

It is our experience of being a nurse that shapes our thoughts about the nature of nursing. According to Husserl (1970a, p. 41), individual existence is 'contingent'—it is dependent on or conditioned by something else. Individual experience is contingent on many things, including all the people we deal with and the circumstances of our lives. As nurses, we experience the nursing task in the same way. Our lived experiences are contingent on whatever phenomena we experience, and everything we experience in relation to others. Consequently, whatever meaning we as nurses find in regard to any phenomenon, this meaning has its roots in the actions of others (Husserl, 1948; Smith, 2007). Everything to do with social behaviour and culture is grounded in the activities of others. How we understand things in the world depends on our consciousness of those things (Husserl, 1970a). Our cultural background is one of the most important factors influencing our perception, and others' perception, of the nursing profession.

3.4 The Theoretical Position of the Research

Since this research aims to explore the lived experiences of Saudi nurses, a qualitative approach was chosen, guided by the philosophical underpinnings of the phenomenological research methodologies described by van Manen (1990).

3.4.1 Phenomenology in Nursing Research

Nursing research uses methods based on Husserlian phenomenology and Heideggerian hermeneutic phenomenology. It has highlighted and acknowledged both approaches and nursing researchers have applied each method to uncover the subjective meaning of the lived experience (Crotty, 1996; Kahn, 2000a; Madjar & Walton, 1999; Polit & Beck, 2006; Rose, Beeby & Parker, 1995; van Manen, 1990). Both these philosophical methods are emphasised in van Manen's hermeneutic phenomenological method, but it is Husserlian phenomenology that is the most appropriate in this research.

The most imperative goal of Husserl's phenomenology is to comprehend human experience as it is actually lived (Husserl, 1913) and 'to explicate, through the analysis of text, the meaning embedded in lived experience' (van Manen, 1990, p. 100). The purpose of utilising this method in this research is to analyse, investigate and describe the nature of Saudi native nurses' situations as nurses at the time of this research. The following section will explore the philosophical position of phenomenology.

3.5 The Philosophy of Phenomenology

'To decide what you should do, rather than what you can do, you must turn to philosophy … they bring clarity and understanding to questions that we should all care about' (Dupre, 2007, p. 3).

The word philosophy is used to refer to wisdom, 'in the broadest sense, particularly learning, knowledge, and truth' (Lee, 1993, p. 192). Philosophy is derived from a combination of the Greek words *philos*, meaning 'love' and *sophia*, meaning 'wisdom' (Comte-Sponville, 2004). Philosophy originates from ancient

Greece and the work of philosophers such as Socrates (c470–399 BC), Plato (428–354 BC) and Aristotle (384–322 BC). Plato's theory of forms (*eidos or idea*) is considered one of the most significant contributions to human knowledge.

To apply 'forms' to phenomenology, we need to contrast between two forms of reality. The unchanging forms, which are the objects of the philosopher's knowledge, are what is ultimately real. The world perceived by the senses, the world of change, though not unreal, has a lower status ontologically than the realm of forms (Husserl, 1970a; Lee, 1993). The difference between the two realms is marked, but for Husserl the difference was simply in the mode of thinking. Husserl (1913) claimed that the world revealed by the senses has only a secondary reality.

The philosophy of phenomenology is the discipline of knowledge. It is an all-powerful system that acknowledges the independent existence of the object. According to Husserl (1931, p. 13), 'philosophy itself is entirely a science a priori'. Husserl throws light on the subject–object distinction that Western philosophy has struggled with (Natanson, 1962; Scott, 1996; Smith, 2003). He treats the traditional subject–object as two separate strands of thought belonging to each other. Their continuity is based on the relation between the knower, on the one hand, and what is known about, on the other.

3.5.1 Philosophy and the Manifestation of Phenomenology

Phenomenology as a method of inquiry was established in around 1905 by Husserl. Its philosophical assumption is based on the premise that reality consists of objects and events as they are perceived or understood in human consciousness and not from anything independent of human consciousness (Thevenaz, 1962). Phenomenologists apply scientific theory in an attempt to understand the person as an individual entity, especially in regard to the person's conscious understanding of

their life-world (Gray, 2002). The term 'phenomenological reality' has been used by humanistic theorists to refer to each person's conscious understanding of the real world (Sokolowski, 2000; Valentine, 1992; van Manen, 1990).

Phenomenology is the study of phenomena. Within phenomenology, the role of the individual and the influence of behaviour are of great importance to phenomenological research and the critique of pure reason (Davidson, Elliott & Daffurn, 2004; Gadamer, 1975; Rigour, 1984; Smith, 2007; Stone, 1979; Valentine, 1992). Moustakas (1994, p. 26) states that 'phenomena are the building blocks of human science and the basis for all knowledge'. What appears in consciousness is the phenomena (Husserl, 1980; Smith, 2007; Teichman & Evans, 1999). Phenomenology is considered to be a significant method of philosophical research because it deals so well with the difference between appearance and reality (Husserl, 1954; Sokolowski, 2000).

Within the science of psychology, phenomenology attempted to integrate the possibility of science in terms of theory of knowledge based on the role individuals played in understanding their nature. As an alternative approach to human experience, phenomenology has been considered an appropriate system for the analysis of properties that mechanistic quantification and reductionist analysis often fail to recognise (Stone, 1979; Valentine, 1992). The scientific study of the individual has highlighted the concept that the individual constitutes a unique pattern that is more than the sum of its component parts and not fully represented by dimensional formation (Smith, 2007; Valentine, 1992). This means that the difference between things as we experience them in everyday life, and the same things as we conceptualise their nature in consciousness, is unrealisable (Husserl, 1954; Smith, 2007). Therefore, as an alternative approach to understanding people, phenomenology moves philosophy towards a more cultural endeavour (Gadamer,

1975; Scruton, 2004) to more understanding of the lived experience of individuals who share the same experiences. Its emphasis on understanding through dialogue is fundamentally distinct from and even opposite to the scientific approach (Husserl, 1954; Scruton, 2004; Snyder, 1988).

3.5.2 The Historical Background of Phenomenology

Phenomenology is derived from the Greek words *phainoemn* or phenomenon, meaning 'appearance', and *logos*, meaning 'reason' (Gearing, 2004). The term phenomenology has had several meanings and has been used in religion, philosophy and physics. The term was used in the mid-nineteenth century (Valentine, 1992) to mean 'to show itself, to manifest something that can become visible in itself, to bring into the light by disclosing the essential meaning of human efforts' (Heidegger, 1962, as cited in Ray, 1994, p. 118). Phenomenology was first used as a concept in the West by Immanuel Kant in 1786 (Cohen, 1987). It was also used in the philosophy texts of Lambert, Herder, Kant, Fichte and Hegel in the eighteenth century (Moran, 2000).

It is interesting to note that modern texts consider the roots of phenomenology only from a Western perspective. The Arabic scholar Ibn al-Haytham is recognised as the world's first scientist: his work on optics, mathematics and philosophy is recognised in both Arabic and Western cultures. Ibn al-Haytham is also acknowledged as authoring phenomenological thoughts and concepts as early as the beginning of the eleventh century (Steffens, 2007). In the eleventh century, Ibn al-Haytham argued that personal experience affects how and what people see. For example, a small child with little experience may have a hard time interpreting things he or she sees. At the same time, an adult can make mistakes in vision because

'experience suggests that he or she is seeing one thing, when really he or she is seeing another' (Steffens, 2007, p. 73).

According to Smith (2007, p. 200), the Germans used the term *phenomenologie*, to mean 'the study of relation between things in the visible world (as opposed, presumably, to deeper spiritual reality)'. Moustakas (1994) points out that the joining of different perceptions, between things in the visible world (different phenomena) enables the perceivers to enter into a synthesis of identification with one another. Moustakas explains that our perception is from whatever angle we view an object, from front, side or back. The synthesis of perceptions means, for example, that a tree that is continuing to present itself as the same real tree will appear different according to different peoples' perceptions of it. However, 'the experienced person will continue to see the tree as just this tree and no other' (Moustakas, 1994, p. 29).

In Steffens (2007, p. 63) we read that Ibn al-Haytham argued that:

'Sight does not perceive any visible object unless there exists in the object some light, which the object possesses of itself or which radiates upon it from another object.'

Although this quotation clearly refers to optics, it also relates to philosophy, which Ibn al-Haytham has a lot to say about. It indicates that to understand the meaning of an object, we need to understand the light inside it. Phenomenology attempts to bring the essence of the subject to the fore—which, in this thesis, is what it means to be a Saudi nurse.

3.5.3 The Concept of Phenomena and its Relation to Experience

Immanuel Kant is generally regarded as one of the main contributors to modern philosophy in general and phenomenology in particular. The concept of

phenomenology started with Kant's philosophical representation of all objects as either phenomena or noumena (Cohen, 1987; Smith, 2007; Strathern, 2002a). According to Russell (1988, p. 86), Kant's most significant contribution was the invention of what he called 'critical' philosophy. Kant's philosophy inquired as to how knowledge comes to be possible. He deduced that we may, with certainty, distinguish what is pure from what is empirical (Russell, 1946, 1988). Russell (1988) points out that Kant contributed two main ideas to modern thinking: first, the perceived idea that 'we have "a priori" knowledge which is not purely "analytic". The second idea makes evident the philosophical importance of the theory of knowledge' (Russell, 1988, p. 2).

Within the scope of the theory of knowledge, the concept of phenomena and their relation to our experience became more popular. Kant argues that there are two elements to be distinguished (Strathern, 2002a). These elements—phenomena and noumena—are important for the theory of knowledge. They explain the relation between the subject and the object.

The physical object, which Kant calls noumena, refers to the thing in itself, and this is important in terms of our experience and knowledge. Russell (1988) claims that Kant regarded the thing in itself as essentially unknowable. What can be known according to Kant is the object as we have it in experience, which Kant calls the phenomenon (Husserl, 1913; Russell, 1946; Strathern, 2002a). According to Russell (1988, p. 81–87), Kant considers that anything we shall ever experience 'must show the characteristics affirmed of it in our *a priori* knowledge, because these characteristics are due to our own nature', which Husserl calls 'the corresponding psychological facts in the context of human consciousness' (Husserl, 1970, p. 308).

In regard to psychological facts and their relation to our consciousness and experiences, Husserl develops the notion (suggested by social scientists) that social facts are characterised and recognised by their meaningfulness to members of the same social world (Bowling, 2002). Husserl (1970) argues that these characteristics can be distinguished only in conscious experiences.

Husserl distinguishes between belief and true belief and holds that we have *a priori* knowledge (from before) which is not simply logical. To understand the objects that we experience through our senses, the term phenomenological reality was used by Husserl. The experiences of each person and their understanding of the real world—the world of consciousness—shape the forms that comprise phenomenological reality (Smith, 2007).

3.6 The Phenomenological Movement

There are various approaches to phenomenology, such as the analytical and continental approaches. The continental approach is linked more to the work of Heidegger and Habermas, while the analytic approach used by Husserl derives originally from Socrates and Aristotle and St Thomas Aquinas (who lived in the Middle Ages) (Holloway & Wheeler, 2002; Smith, 2007). During the twentieth century, phenomenology has been the main component of continental philosophy, as opposed to the analytic tradition that has characterised philosophy in England and the US (Smith, 2003; Sokolowski, 2000; Stone, 1979).

The history of phenomenological thought is described by the historian Spiegelberg (1984) as a 'phenomenological movement'. The movement of phenomenological thought began in Germany before 'influenc[ing] many other philosophical and cultural movements, such as hermeneutics, structuralism, literary formalism, and deconstruction' (Sokolowski, 2000, p. 3). Spiegelberg reviewed the

philosophical root of phenomenology and distinguished three phases. These phases are the preparatory phase, the German phase, and the French phase.

3.6.1 The Preparatory Phase

The first phase of the movement was the preparatory phase and included the pioneers of phenomenology, Franz Brentano (1838–1917), Carl Strumpf (1848–1936) and Edmond Husserl (1859–1938) (Smith, 2003). Phenomenology was first proposed by Franz Brentano (1874) in the first half of the nineteenth century (Smith, 2007), while, 'experimental phenomenology is regarded as beginning with Strumpf' (Crotty, 1996, p. 116), who demonstrated the scientific rigour of the method (Cohen, 1987).

The starting point of this phase is Brentano's distinction between the natural sciences (which investigate physical phenomena such as sensations) and the human sciences (which investigate mental phenomena, particularly perception, memory and judgment) (Moustakas, 1994; Smith, 2007). The significance of Brentano's contribution includes an emphasis on the value of internal perception or intuition[13] (instinctive knowledge or belief). This was considered by Brentano to be awareness or insight that a person develops about their own individual mental phenomena. Brentano's contribution also includes the concept of intentionality. Brentano (1874) believed that the intentionality of a human being cannot be separated from the world in he or she lives (Cohen, 1987; Husserl, 1913). Brentano maintained that the contents of consciousness are of two types; those which represent physical reality (external phenomena) and those which belong to the mental realm (natural

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[13] The state of being aware of or knowing something without having to discover or perceive it, or the ability to do this; something known or believed instinctively, without actual evidence for it (Blackburn, 2005).

phenomena or mental phenomena) (Scruton, 2004, p. 242). Brentano (1874)

distinguished between mental acts and mental contents and claims that mental

phenomena should be distinguished from physical phenomena (Brentano, 1874, p.

96). According to Brentano (1874), there is intentional content in all mental acts.

Brentano asserts that:

> 'We have no right to believe that the objects of so-called external
>
> perception really exist as they appear to us. Only what we know
>
> from internal perception can be counted on as a basis for scientific
>
> knowledge' (Moustakas, 1995, p. 44).

3.6.2 The German Phase

The modern phenomenological movement—also known as the German

phase—began prior to World War One with two major figures in German

phenomenology: Edmund Husserl (1859–1938) and Martin Heidegger (1889–1976),

a student, and later rival, of Husserl (Walters, 1995).

The concept of phenomenology has often been misinterpreted. Husserl (1954,

pp. 262–263) pointed out that such misinterpretation often occurred in discussion

over whether phenomenology was a form of 'realism' or 'idealism':

> 'All previous discussions of idealism and realism have failed to
>
> penetrate to the consciousness of the genuine problem which lies,
>
> sought for but undiscovered, behind all theories of knowledge;
>
> much less have they grasped the transcendental reduction in its
>
> difficult sense as the gate of entry to genuine knowledge of self and
>
> of the world.'

Husserl's phenomenology became the most influential force not only upon Heidegger but also upon the whole generation of German and French philosophers (Barrett, 1962). In this research, the framework of the philosophical principle of Husserl's phenomenology provides the design that prescribes how the methods of phenomenology should be used. The phenomenology of Husserl will be discussed after the following section, as Husserl's works have informed this thesis.

3.6.3 The French Phase

The French philosophers who were influenced by Husserlian phenomenology include Gabriel Marcel (1889–1973), Emmanuel Levinas (1906–1995), Jean-Paul Sartre (1905–1980), Maurice Merleau-Ponty (1907–1960) and Paul Ricoeur (b. 1913) (Sokolowski, 2000; Zahavi, 2003). Existentialism was a significant aspect of this phase. The French philosopher Jean-Paul Sartre is known as the most significant existentialist of the twentieth century (Cohen, 1987; Strathern, 2002b). His philosophy was concerned with 'being'. According to Strathern (2002b), Sartre found that the essence of being lies with self-rule. Sartre believed in the freedom of choice and the reality of self-determination.

Another prominent representative of existentialism was Merleau-Ponty (1907–1960). His focus was on the 'phenomenology of perception', which emphasised the fact that perception can be perceived and described. It also emphasised that people aware of their existence can perceive characteristics of their essence, understand them and express them (Giorgi, 1985; Husserl, 1954; van Manen, 1990). In the introduction to *Phenomenology of Perception* (1962, p. xi), Merleau-Ponty defined phenomenology as 'a manner or style of thinking … It existed as a movement before arriving at complete awareness of itself as a philosophy'.

3.7 Husserlian Phenomenology

3.7.1 Introduction

> '[Phenomenology] systematically demands a definite clarification, analysis and description shedding light on the essential connexions and penetrating to the remotest specifications attainable: it demands thoroughgoing [systematic] work' (Husserl, 1913, p. 417).

Edmund Husserl (1859–1938) was a German philosopher. He was born in Prossnitz, Moravia, and was educated in Vienna and Berlin, first in mathematics and later in philosophy. Later, he taught and wrote philosophy in Germany (Smith, 2007). Edmund Husserl was one among many philosophers who shaped the thought and culture of modern Vienna and his philosophical beliefs influenced the culture of modern society as a whole (Barrett, 1962; Scruton, 2004; Smith & Thomasson, 2005). Husserl is best known as the principal founder of phenomenology, which he defined as the study of the essence of consciousness as experienced from the first-person point of view (Husserl, 1913; Scruton, 2004; Smith, 2007).

Husserl's methodology was structured on a systematic philosophy influenced by Aristotle, Avicenna and Kant, and in which phenomenology plays its special role (Smith, 2007). His mentor was Thomas Masaryk, a student of Brentano who later became the first president of Czechoslovakia (Lyneham, 2004). Husserlian phenomenology is a descriptive method used to analyse the structure of given experiences thematically (Husserl, 1970a). Husserl (1913), following Brentano's psychological description of our mental phenomena, recognised the ability of human consciousness and intuition, which led Husserl to develop the concept of transcendental phenomena (Moran, 2000; Moran & Mooney, 2002).

The traditional challenge between the subject and object initiated the subjective emphasis of Husserl's phenomenology (Husserl, 1913). In phenomenology, Husserl's transcendental self was an attempt to establish the theory of social reality (Hopp, 2008; Scruton, 2004; Zahavi; 2003). Husserl's transcendental phenomenology provided ultimate reality to subjective experiences (Moran, 2000; Moran & Mooney, 2002; Scruton, 2004) and established a science of phenomenology that changed the course of European thought (Moran, 2000; Moran & Mooney, 2002; Smith, 2007; Zahavi; 2003).

Husserl's chief contributions to modern thought were the concept of the life-world and the phenomenological method (Cohen, 1987; Smith, 2003). Husserl (1931, 1970a) argued that the methods of science were useful, but incomplete for the human discipline. To show this, Husserl established a science of human experience, an account of the relation between subject and object and between language and experience (Smith, 2007; Zahavi, 2003).

Husserl's phenomenology became the most dominant of the German philosophers' approaches (Barrett, 1962). Husserl's work *Logical Investigations* is considered as the initial statement of the phenomenology movement (Sokolowski, 2000; Zahavi, 2003). Husserl considered phenomenology to be a philosophy, an approach and a method (Smith, 2007; Ray, 1994). According to Husserl (1970), phenomenology is a method of philosophy, 'one that conforms to the issues raised by modern thought' (Sokolowski, 2000, p. 3). While rejecting some of Kant's insights, Husserl (1913) was inspired by Kant's division between practical reason, and understanding. Husserl extended Kant's ideas on a pure phenomenology and on a phenomenological philosophy. He added to Kant's theories about rationality and empiricism and about epistemological and ontological assumptions (Scruton, 2004; Smith, 2007; Zahavi, 2003). Husserl's ideas attempted to develop the concepts of

intelligence, in particular those concepts that related to mental phenomena (Moran, 2000; Moran & Mooney, 2002; Scruton, 2004; Smith, 2003).

As a phenomenological inquirer, Husserl could neither think outside the framework of 'transcendental idealism', nor abandon the Kantian 'critical philosophy' (Scruton, 2004). Husserl's ideas extended Kant's speculations about idealism and his relativist assumptions concerning science and the possibility of human knowledge (Scruton, 2004; Smith, 2007). Husserl (1913) further developed the concept of 'phenomena' proposed by Kant along with the characteristics of intentionality.

Husserl drew on the 'conclusions concerning what the world-as-it-is-in-itself (what Kant calls the noumenal world) is like' (Law, 2007, p. 104) and structured the transcendental aspects of subjectivity. For Husserl, the achievement of transcendental idealism consisted in overcoming the thing in itself. This meant, in Husserl's interpretation, that objects outside us are constituted within the mind of a self-conscious subject (Husserl, 1913; Scruton, 2004; Smith, 2007). Husserl calls noumena the thing in itself (Greenberg, 2001, p. 39), which eludes our attempts to describe it, while the forms of intentional objects as we experience them he regards as phenomena (Husserl, 1913).

Husserl's conception of phenomenology as a philosophical method raises the question of what is happening in the subject, in themselves, as they live; that is, what is happening in reality; how is the subject linked to external and natural objects and how does this correlate, intentionally or otherwise, with consciousness. Further, Husserl's phenomenology asks how the phenomena that relates to a mental existence, which is not attached to matter at all but which is attached to non-corporeal matter, might be predicted (Husserl, 1950).

Husserl developed a phenomenological methodology, taking into account epistemological and ontological assumptions (see Section 3.3.3) and established the experiential of human experience—an account of the relation between subject and object and between language and experience (Lawlor, 2002; Smith, 2003; Sokolowski, 2000). Husserl 'holds that language expresses the content or 'sense' of an underlying form of experience' (Smith, 2007, p. 200) and provides an account of the conditions for the possibility of human knowledge, 'in particular, human theoretical knowledge' (Fink, 1933, as cites in Lawlor, 2002, p. 12).

As a method of thinking (Merleau-Ponty, 1962, p. xi), Husserl's phenomenology 'aims to disclose and clarify the true epistemic [knowledge] and ontological significance of consciousness' (Kupers, 2009, p. 55). Husserl makes a physical effort to construct the phenomenological method of thinking with the epistemological question, 'How do we know?', and with the ontologic or metaphysical question, 'What is being?' Philosophy's first concerns are with the ontological question of existence and the fact that philosophy has been affected by culture and language (Lawler, 1998; Ray, 1994). According to Ray (1994), the ontological questions are often preceded by epistemological inquiry. From a cultural point of view, these questions are proposed to clarify the meaning of the language expressed by the people of any given culture (Husserl, 1954; 2003).

3.7.2 Possibilities for Knowledge and Experience

Fundamental beliefs about the possibility of knowledge and experience stem from the fact that:

> 'Human science is rationalistic in that it operates on the assumption
> that human life may be made intelligible, accessible to human

logos or reason, in a broad or full embodied sense' (van Manen,

1990, p. 16).

This is supported by the philosophical conclusion of the theory of knowledge—that knowledge is true belief with a rational account of why the belief is true (Alchin, 2006; Dupre, 2007; Law, 2007; Lee, 1993).

Surely the natural and the social sciences, as well as the conduct of society's affairs, cannot prosper without a careful and reliable respect for clarity in reporting the facts (Frankfurt, 2007; Sokolowski, 2000; Tilley, 2004). It is important to maintain this respect of truthfulness. We cannot deny the validity of any given situation just because we cannot qualify it as true. If we believe something to be true we should accept it, otherwise how can we distinguish an objective reality between being true and being false. If we do not have a respect for the truth then there will be no objectively meaningful or worthwhile distinction to be made between what is true and what is false. In the words of Sokolowski (2000, p. 4):

'Many philosophers have claimed that we must learn to live

without "truth" and "rationality", but others try to show that we can

and must exercise responsibility and truthfulness if we are to be

human.'

The primary aim of objective science has been not only to generate knowledge of the life-world, but also to elucidate and predict future phenomena and actions on the basis of that knowledge. Positivist views concerning the theory of knowledge argue that knowledge can be acquired only through direct observation and experimentation and not through metaphysics or theology (Valentine, 1992). Tilley (2004, p. 1) points out that 'science is a process of acquiring knowledge and a means of trying to understand reality and reveal the truth'.

3.7.3 Objective Science

Objective science relates to a human being's ability to react or respond to a specific set of conditions using their judgment. Husserl (1970) proposed that there were ideal objective meanings of eternal thoughts and claims that without ideal meaning, judgment can only be about the contingent ways that people happen to reason. According to Husserl (1970, 2003), it is in this direction that psychologism lies; that is, the reduction of logic to psychology.

Before proceeding further into an inquiry into Husserl's phenomenology, it is essential to trace the process by which Husserl moved theoretically from observations (empiricism) of the real world to systematic ideas (idealism) about the world. Valentine (1992, p. 198) cited Schutz (1932) to say objective science can have no other basis than 'the already constituted meanings of active participants of the social world'.

Through Brentano, Husserl became interested in the empiricist philosophy of David Hume (1711–1776), whom Husserl often reported as a genuine antecedent of phenomenology 'as Hume mapped the different kinds of mental activities' (Smith, 2007, p. 16). Husserl was also involved with the work of Bernard Bolzano (1781–1848), whose conception of logic proved a vital motivation in Husserl's development of phenomenology. Husserl also likened phenomenology to the work of several of his contemporaries, who had applied the methods of natural philosophy (Smith, 2003), and it was from Brentano that Husserl learned of the Mediaeval 'theory of intention': the mind's aiming at objects in thought or perception (Husserl, 1913).

The modern scientific method has been developing constantly. In the seventeenth century, Francis Bacon was a key figure in the evolution of objective science (Radcliffe, 2000). Bacon's assumption regarding the science of man included

a balance of observation and reasoning. However, in his study of natural phenomena he recognised the possibility of fallacious thinking due to social and personal biases (Radcliffe, 2000).

For objectivity, the relationship between subject and object must be unbreakable. Husserl holds that the transcendental self constitutes the unity of all conscious acts; it constitutes a subject-oriented stream of internal time-consciousness (Husserl, 1980). Moreover, the object that appears in its unity appears only through an object-oriented analysis (Andrews, 2007; Smith, 2007). Husserl's phenomenology explored the ways in which time (internal time) sheds light on how the essence of experiences is constituted as a process (Husserl, 1980) or 'unitive stream of internal time-consciousness' (Andrews, 2007, p. 118).

The primary examples of how Husserl described the relationships between subject and object are related to the unity of the subjective and objective idea of the aesthetic experience and its realm. In phenomenology, the researcher needs to distinguish between subjective and objective ideas. According to Husserl (1970), the subjective ideas only become known in our individual minds in the temporal flow of our experience. However, objective ideas are not in space or time. Husserl supposed that objective ideas are like Platonic forms. Therefore, objective ideas are like ideal forms of thinking. Thinking is always thinking of something, in willing we always want something and so on (Husserl, 1948). Husserl held that logic is about objective ideas, not subjective ideas (Husserl, 1970).

In the philosophy of science, some philosophers, such as John Stewart Mill and Bertrand Russell, thought that the uniformity or consistency of nature could be established based on empirical inductive knowledge (Russell, 1988). Rationally, Husserl offered a practical justification of induction. According to Russell (1988), since the scientific method was certain and had been proven, it would seem rational

to accept induction as being certain. Empirical inductive knowledge provides a suitable basis for the formulation of scientific law. 'Induction presupposes causality and causality presupposes the consistency or uniformity of nature' (Al-Ghazali, 1997, pp. 170–181).

Logic is the science of analytical argument and it establishes principles or foundations on which sound inferences can be made (Smith, 2007). In logic, the concern is not with the particular content of the arguments in which different views are expressed, but with their general structure and the form of the argument itself. Husserl (1970) considered logic as ultimately concerning the realm of human thoughts (Gedanken), stating that since language expresses thought, the true medium of logic is not language but meaning (that is, thought) (Husserl, 1948, 1970).

The key component of logic is the semantic theory of sense and reference. Semantics concerns meaning in language and that which particular expressions represent or refer to (Smith, 2007). Husserl criticised the competing scheme of the theory of language and established the principle of logic, which distinguished ideal sense from objective references (Husserl, 2001). Husserl held that subjective ideas only become known in our individual minds in the temporal flow of our experience and that they are like Platonic forms (ideal forms of thinking).

The ideal meaning was part of the main focus of Husserl's *Logical Investigations*. He stated that ideal meaning comprised the propositions that make up a theory (Husserl, 2001). For Husserl (1970), propositions are expressed in language and by this means communicated and shared with others who speak and understand that language. In Husserl's view, the meaning represented by the expression is a form. The meaning of any expressed forms in a language can represents things in the world and thus, certain forms of meaning represent certain forms of objects (Husserl, 2001). With the development of semantics of the ideal sense, Husserl distinguished

the sense (*sinn*) of an expression (its ideal meaning) from the object: that which it represents or stands for (Smith, 2007).

Language expresses a sense and a reference, with the sense referring to the content of what is being thought. Two expressions in a well-defined language may have the same reference but express difference senses. Smith (2007) gives the example of 'the morning star' and 'the evening star', with both references referring to the planet Venus. However, despite having a common reference, the two terms have different senses, with differing conceptual values (in relation to the morning and evening star). The phenomenologist's main concern is to understand how meaning relates to our conscious experience. Thevenaz (1962, p. 9) argues that 'Phenomenology is neither a science of objects nor a science of the subject; it is a science of experience'. The method of phenomenology aims to investigate and describe conscious experience in all its varieties without reference to the question of whether what is experienced is objectively real (Husserl, 1913).

Under the rule of logic, Husserl (1970) considered the principle of objective science and argued against the way in which mechanistic quantification and reductionist analysis was used. Husserl criticised psychological analysis (psychologism), the theory used by psychology as a method of resolving philosophical problems (Smith, 2007). Husserl (1990) claimed that psychologism is the attempt to reduce the fundamental laws or rules of judgment and the theory of probability to psychological generalisations about the ways in which people actually think. According to Husserl (1970), it is clear that a true belief cannot be called knowledge when it is deduced by a fallacious process of reasoning, even if the premises from which it is deduced are true (Russell, 1988).

It is not enough that our premises should be true; they must also be known (Russell, 1988). Therefore, knowledge is what is validly deduced from known

premises (Russell, 1988; Smith, 2007). In this context, the lived experiences became *a priori*. If we cannot deduce, infer or conclude anything from our experiences, we will not be able to reason and acquire knowledge and truth. In fact, we cannot reason at all, in any subject matter (Husserl, 1970).

Husserl (1970) points out that the basic idea of objective science is reliant on its task, the task of finding non-relative truths about the world. This is the task the Greeks defended by distinguishing between appearance and reality. Science defines itself as 'a system of objective propositions in themselves, composed of objective ideas-in-themselves' (Smith, 2007, p. 47). Husserl (1970), in his *Logical Investigations*, supports this view, stating that whatever knowledge is *a priori* must be analytic or systematic (Husserl, 2001).

Husserl (1913, 2001) agreed with the view that it was not only the connections of cause and effect that were synthetic (as opposed to analytic) but also all the propositions of arithmetic and geometry. In all these propositions Husserl argues that no analysis of the subject will reveal the predicate. Conversely, Russell (1988) claims that there are many ways, besides logical inference or deduction, by which we pass from one belief to another: the passage from the print to its meaning illustrates these ways. Russell, like Husserl (1970, p. 134) called this 'psychological inference'. Husserl (1954, p. 6) concludes that:

> 'The mere science of [systematic] bodies clearly has nothing to
> say; it obstructs from everything subjective. As for the humanistic
> sciences, on the other hand, all the special and general disciplines
> teach of man's spiritual existence, that is, within the horizon of his
> historicity: their rigorous scientific character requires, we are told,
> that the scholar carefully exclude all evaluative positions, all

questions of the reason or unreason of their human subject matter

and its cultural configuration.'

Husserl (1913, p. 209) points out that phenomenology aims to be 'a

descriptive theory of the essence of pure transcendental experiences'. In this sense,

phenomenology precedes other studies. Its aim is to constitute the essential

preconditions of experience and knowledge (Smith, 2007). For the possibilities of

knowledge and experience, every 'theoretical accomplishment in objective science

has its place on the ground of the pre-given world, the life-world' (Husserl, 1954).

3.7.4 The Nature and Knowledge of Essential Being

Methods of determining truth mainly involve objective knowledge and the

way knowledge is acquired and validated. These methods are used to distinguish

between appearances and reality, between what is right and what is wrong, clarifying

the pure relative true and avoiding the non-relative true about the world—our life-

world. These methods are a necessary condition for the science of essential being,

which, according to Husserl, lies in the purity of our self. This purity of the self is

the essence of our soul, and it is attainable by contemplation: 'no science which

cannot be examined by the balance of commonsense is certain and exact' (Inati,

1984, p. 71).

For the science of essential being, objective knowledge is restricted to

knowledge of particular beings or things (Husserl, 1913). As a philosopher, Husserl

has to bring in his philosophical thinking and in particular his theory of

phenomenology. For Husserl (1954), all the objects we experience through our

senses are particular forms. The world (universe) is pre-given as a universe of

particular forms. According to Lee (1993, p. 192), 'the word "form" is now the

common rendering of the Greek eidos or idea. The older rendering, the idea, is avoided because of its misleading suggestion of a purely subjective notion'.

Particular things contrast with knowledge of forms through opinion or belief (Smith, 2007). In Husserl's phenomenology, things are analysed into two forms of existence, an external form and an internal form, while being is categorised into the realm of relative being and absolute being. External forms come under the realm of relative being and internal forms fall within the realm of absolute being. Relative being is related to our surrounding environment, while the absolute being refers to being in consciousness (Husserl, 1913).

Husserl (1954, p. 227) concludes that:

'Things have their concrete set of forms, finding their expression in the "substantives" of a given language. But all particular sets of forms come under the most general category of all, the set of 'regional' forms.'

Husserl called relative being 'the former' and absolute being 'the latter'. The latter can help identify not only what is true and valid, but also what is false and invalid (Inati, 1984, p. 71).

He refers to the latter also as '*meon*' (non-being). However, there is also a difference between being as consciousness and being as reality. This difference is based on the distinctions Husserl made between the whole and the part. Husserl followed Brentano in analysing mental phenomena and established the theory of part and whole. The whole (*concretum*) refers to something that exists for a specific individual, which, in turn, can also be experienced and approached in a concrete way (Husserl, 1950). Conversely, the parts are the particular individual material objects that exist (Inati, 1984). Husserl distinguishes the mental phenomena (internal

existence) into their parts and moments (a moment being a non-detachable characteristic like intensity) (Scruton, 2004). Moments are dependent on the parts. Husserl held that the moments are remote from the forms or from the particular material objects (Husserl, 1931). The parts are associated with the material objects of which they are pictures of concepts we hold in thought, which in turn are responses to material objects (Inati, 1984; Husserl, 1913).

Part and whole are two different ontological assumptions that influence Husserl's ideas in his phenomenology. In phenomenology, the meaning of the phenomena is part of our life-world and reflected as a whole. Consequently, the main focus of the phenomenological method is to grasp the whole meaning of the experience, instead of dividing it into parts without understanding the basic structure. This gives sense to the whole experience as revealed by the participants (Aanstoos, 1985; Kupers, 2009; Sokolowski, 2000). Researchers cannot grasp a sense of the whole of a given experience by separating the parts from the general context on which every part is based. If researchers were to do so, they would be approaching the lived experienced from their own perspective, which would be detached from the sense of the whole of the experience for the person who lives it (Smith, 2007; Sokolowski, 2000).

In addition, Smith (2007) and Sokolowski (2000) claim that the parts cannot exist apart from the whole to which they belong. However, these parts are not concrete things, but only abstract objects. Therefore, these parts are thought of conceptually or theoretically as abstractum (Smith, 2007; Sokolowski, 2000). Sokolowski (2000, p 25) states, 'there is always a danger that we will separate the inseparable, that we will make the abstractum into a concretum'.

3.7.5 The Phenomenological Reality of the Life-World

3.7.5.1 Introduction

Individual conceptions of 'life' and 'the world' have differed widely and the differences often involve adherence to inherited religious and ethical conceptions of the life-world (Russell, 1946). This is particularly important for this research, because of the inherited nature (which Husserl calls 'immanent') of the beliefs of the individuals involved. Nurses cannot divorce themselves from the contexts of their culture, religion, language, economy, political system and society. This is especially true in Saudi Arabia, where all factors are intrinsically linked.

Through our conscious experiences we learn the facts about our own life-worlds. This is consistent with respect to our lived experiences, intentional characteristics, language and the priorities required of our culture. All these aspects define us and comprise our world: the world of our consciousness (Husserl, 1980).

From a phenomenological point of view, to understand the meaning of being-in-the-world, an individual's knowledge of their life-world and their knowledge of their own physical world is necessary (Husserl, 1980; Zahavi, 2003) because meaning is the core of phenomenology (Husserl, 1931, 1948; Smith, 2007).

To conduct research using Husserl's phenomenological approach is to question the way the world is experienced and to show the characteristics of being-in-the-world as they are experienced. To be in the world is to know more fully the world in which we live as human beings. According to van Manen (1990), to know the world is to be the world: we have an inseparable connection to the world that phenomenology calls 'intentionality'. Van Manen (1990, p14) states:

> 'The human being is a person who signifies, gives and derives
>
> meaning to and from the "things" of the world. In other words the

"things" are meaningfully experienced, and on that basis these

"things" are then approached and dealt with.'

According to Husserl (1913), in genuine sciences, things themselves, as they are in themselves, are determined. Husserl points out that what manifests itself in the immediately intuited world—the world of our pre-scientific experience—is self-evidently (despite its relativity) a world that is actually in being, even if its intrinsically true character transcends straightforward experience.

Husserl (1954, p. 226) argues that 'straightforward experience, in which the life-world is given, is the ultimate foundation of all objective knowledge'. To understand 'we must understand not only our inheritance of the "ready-made" science … but also our inheritance of the very idea of science' (p. 280). According to Husserl (1954, p. 226):

'One must not operate with empty word-concepts, must not move in the sphere of vagueness, but must derive everything from clarity, from intuition, or, what is the same thing, from what is self-evident.'

Thus, if we wish to clarify the true status of ideal logical principles or real physical objects we have to turn towards the subjectivity that experiences these principles and objects, for it is only there that 'the appearances show themselves as they are in consciousness' (Zahavi, 2003. p. 12).

The philosophers of science suggest that science can only model itself on its own subject matter (Valentine, 1992). In this sense, Edmund Husserl integrated ideas into mathematical concepts and discovered a psychological perspective on the phenomenal world. In his early works, Husserl acknowledged the theoretical ideas of

philosophers and discussed his exploration of the relationship between mental

processes and mathematical concepts (Husserl, 2003; Smith, 2007).

Husserl's phenomenology threw light on issues that concerned psychology.

Through phenomenology, Husserl clearly identified 'how an object (a perceived

object) reveals itself as being' (Husserl, 1954, p. 159). Husserl deliberately, and

carefully, examines how the appearance of a thing in its actual and possible

manifestations change; leading him to realise the correlation involved. This

correlation between appearance and that which appears as such is essential for

phenomenological research. The concept of the life-world 'presupposes pre-

scientific knowing and the purposive reshaping of the latter' (Husserl, 1954, p 165).

3.7.5.2 The Concept of the Life-World

In Husserl's later years, he expanded on his phenomenological method, and

the concept of the life-world arose (Smith, 2007). He underlined the importance of

our intimate engagement in experiential life and highlighted the view of how

description enhances our awareness. For Husserl, this view was a starting point,

which he claims is 'better than an explanation' (Todres & Holloway, 2004, p. 81).

According to Husserl (1954, p. 226):

> 'We already know that all theoretical accomplishment in objective
>
> science has its place on the ground of the pre-given world, the life-
>
> world that presupposes pre-scientific knowing and the purposive
>
> restructure of the latter.'

The concept of the life-world was of great importance to Husserl, particularly

in regard to the problems of *a priori* knowledge. Since our scientific conception of

nature diverged from our everyday experience of the world, the 'world of everyday

life' is our approach to other people and is fundamentally distinct from the natural

approach of science. Valentine (1992, p. 178) claims, 'Science constitutes rather than discovers the world'. As a result, relations must be placed in a world that is neither mental nor physical (Russell, 1946; Zahavi, 2003). According to Russell (1988, p. 88), it is very common among philosophers to regard what is *a priori* as in some sense mental: as concerned with the way we must think rather than with any fact of the outer world.

Husserl (1913) outlined the character of the world around us, '*Umwelt*', as 'the world of everyday'. He categorised the ontological structure of objects, persons, actions and institutions in the life-world. In Husserl's philosophy, the concept of the life-world involves the lived experience of human being, the possibility of action and personal language (Husserl, 1948; Scruton, 2004). With pure phenomenology, Husserl (1917) was able to understand the realm of meaning in human science. He calls the commonsense world the '*Lebenswelt*' (the life-world) (Smith, 2007) and 'distinguished it from the science of the explanation (the realm of nature)' (Scruton, 2004, p. 245). According to Gadamer (1975), the commonsense-life-world was understood as a purely theoretical faculty, a theoretical judgment on a level with moral consciousness (conscience) and taste. Commonsense is concerned only with things that we see daily before us, experiences that hold an entire society together, things that are concerned both with truths and proposition statements and forms of probability statements.

The life-world is our world and it is constituted by our social interaction and our actions, combined with the meanings that inhabit our communicative acts (Husserl, 1970; Scruton, 2004). Yet, to live through empathy (*Einfuhlung*), Husserl stresses, we experience 'other I's'. The focus shifts from 'to be' to 'being' and from 'I' to 'we'. This 'being' joins us with others in social activities and institutions (Husserl, 1948; Scruton, 2004).

3.7.5.3 Consciousness, Nature and Culture

Generally, within the world around us, the nature of our life-world is culturally constituted by our social interactions and, in this way, empathy emerges from our understanding. Jagtenberg and D'Alton (1989) point out that this external nature is a world of raw material, an unquestioned source of delight and entertainment for most people.

Phenomenological reality encloses the relations between the consciousness, nature and culture of the person and is linked to the concepts of the whole and the part (Smith, 2007). This relationship is important and includes extended accounts of ourselves, as human beings. When I act, my action is a complex whole with parts that include my desire or willingness, my physical body's response to my willing and the effects of that movement on the act. Under the essence of my consciousness, my desire is an event with a moment of intentionality (Husserl, 2006, 1913). However, as a whole, dependent parts fall into the distinct region of human consciousness, nature and culture (Smith, 2007).

According to Husserl (1954) I am the subject of intentional experience, such as I think, will, perceive and love. As a subject, compliant with the essence of nature, I have a physical body; I have a certain mass (amount or sum) and height (distance, or intensity). I experience physical objects around me not as simply existing (spatiotemporal) and material in composition, but as objects for the purpose of being objects, that I deal with in a particular activity. As a Saudi person among 'others', I interact in a social context with those in my society. Therefore, from a cultural perspective, I am subject to moral and legal principles, which are required to be in harmony with the essence of our culture (Husserl, 1954, 1913). Phenomenological realities are united as moments of the individuals that we are. They create our belongingness. As such, these moments are bound together by conscious

experiences, as my current thoughts depend on hearing, seeing and being conscious (Husserl, 1913; Smith, 2007).

3.7.5.4 The Possible World

Logicians have formulated various concepts of morality based on logic or semantics (Smith, 2007). Husserl (1970) considered the possibility that the 'life-world' was a source of evidence beyond our existing understandings and that, if attended to more faithfully, it could provide new productive insights. Husserl argues that 'the concrete affairs (Sachen) of everyday life ought to provide the basis for philosophical reflection' (Todres & Holloway, 2004, p. 81).

For Husserl, the possible world is essentially correlated with intentionality. What can be known is the object as experience, as an intentional object that he calls phenomena. The life-world has characteristics stemming from our experiences and conforming to our *a priori* knowledge. As a result, 'nothing can ever come into our experience without acquiring these characteristics' (Russell, 1988, p. 85). Further, nothing can come into our possible world without understanding and structuring the lived experiences. In the case of this thesis, this refers to the life-world of Saudi nurses. According to Hare (1964, as cited in Johnstone, 2000, p. 8):

> 'In a world in which the problems of conduct become everyday more complex and tormenting, there is a great need for an understanding of the language in which these problems are posed and answered. For confusion about our moral language leads, not merely to theoretical muddles, but to needless practical perplexities.'

According to Husserl (1970), formal logic enables one to construct proofs, but, in logic or semantics, philosophy does not identify the meanings of expressions.

Logicians have formulated the so-called possible worlds by the semantics approach, which states the conditions in which assertions or statements are true in a given world. Therefore, a statement of the form: 'A is possible', is taken to be true in the real world provided that 'A' is true in at least one possible world that conceptualised and reflected a future possibility (Smith, 2007).

This model becomes the possible world of formal logic, through semantic analysis in the formal language. Within this framework, according to Smith (2007), Husserl analyses the concepts of acceptable and necessary in terms of possible worlds relating to the concept of moral obligation: if I am obligated with consciousness to do x, then in an ideal world I do x (Husserl, 1913).

3.7.6 The Model of Consciousness and Transcendental Experience

According to Husserl (1970), the philosopher's task is to contemplate the essences of a thing by systematically examining that object in the mind. As such, Husserl defined phenomenology as the science of the essence of consciousness (Husserl, 1913). According to Husserl, consciousness is intuitively obvious, with everyone having immediate knowledge of it.

Consciousness is the medium of our existence as human beings who see and desire and reflect (Husserl, 1980). Phenomenology offers a method to search the essence of consciousness as experienced from the first-person point of view. Consciousness, according to Husserl, consists in our experiences of various types: seeing, touching, imagining, thinking, judging, desiring, feeling, willing and so acting (Husserl, 1980).

Consciousness is special because we experience it and live through it, with each of us experiencing it in our own way. This is important because the very essence and the real meaning of consciousness includes all kinds of things we

encounter in our own experience (Smith, 2007). Husserl considered how the object is

subjectively constituted and emphasises an understanding rather than an explanation.

The phenomenological method is concerned with the essential characteristics of

consciousness necessary to constitute the world of objects, which is considered

crucial to understanding the meaning of a situation for the participants (Smith, 2003;

Valentine, 1992; Zahavi, 2003).

Husserl held that only through meaning does consciousness present us with a

structured world of things, which includes ourselves (Moran, 2000). Husserl (1913)

pointed out that consciousness contains ideal, unchanging structures called

meanings, which determine what object the mind is directed towards at any given

time. This means that consciousness involves the nature of being human and the way

we think and know the essence of the things that appear in our life-world as we

experience them from our first-person point of view. This was the reasoning behind

Descartes' famous proclamation: 'I think, therefore I am (*cogito ergo sum*)' (Smith,

2007, p. 56). However, in contrast to this principle, Husserl (1913) claimed that the

cogito (I think) is the principle of the pure ego (pure consciousness), which

phenomenologically conducts the processes of reasoning such as seeing, thinking or

desiring. Husserl asserts that every actual *cogito* has an intentional object (that is, it

is a consciousness of something) and that, simultaneously, the *cogito* may itself

become a *cogitatum* (thought, reflection or idea) if the principle that 'I think' or

experience becomes an object of consciousness.

For objective knowledge and the critique of pure reason, according to Smith

(2007), the principle of pure ego follows the rule of the performance of an act of

judgment. In the *cogito*, the act of judgment is itself an intentional object. In this

case, the phenomenological method mainly engages *cogito*, in which the pure insight

is inner awareness that aims to represent an act of pure consciousness. The

phenomenologically reduced *cogito* is a suspension of judgment about the question of whether thinking implies existence (Husserl, 1970). Phenomenology examines the *cogito* as pure intuition and as an act of pure consciousness.

Titchener (1987, as cited in Valentine, 1992, p. 36), defines consciousness as 'the sum total of a person's experiences at any given time'. Consciousness is self-reflective and involves a series of alterations in perspectives (Husserl, 1980). Reflective consciousness is typified by inner perception or vision, which is closely related to language and social functions (Moustakas, 1994; Smith, 2007; Valentine1992). One characteristic of consciousness is that it has the ability to embed models recursively. It could possess a model of its own operating system (including options available to it) and thus contain self-awareness and intentionality (in both senses: propositional knowledge and the use of knowledge to influence action) (Valentine, 1992). Conscious reflection appears to be necessary for the acquiring of narrative cycles of behaviour, which extend the operations of available application to new contexts, such as enabling a change from the external mode of behaviour to the internal mode of thinking (Smith, 2007; Valentine, 1992). Consciousness itself is absolute being, while the spatiotemporal world is merely phenomenal being (Husserl, 1913).

Elements of consciousness, such as perceiving, willing, thinking, remembering and anticipating, are modalities in our self-world relationship. In the context of this research, they give the researcher access to the shared world of Saudi nurses and to the worlds of other Saudi nurses, by reflecting on the content of the Saudi's lived experiences encountered by the researcher 'and also by reflecting on the process' (Kupers, 2009, p. 54).

The phenomenological method is used to investigate the essential nature of consciousness (Husserl, 1913). Husserl (1970) stresses that phenomenology is

concerned with the essence of what is immanent in consciousness and with describing immanent essences. However, with the principle of the pure ego, pure consciousness performs acts of consciousness (cogitations), which may be immanently pure and/or transcendently directed.

Husserl's transcendental phenomenology links being-in-the-world and being-of-the-world, as we experience the world. Transcendental experience confers meaning by the act of the knowing ego, or self, reflecting on itself (Husserl, 1913). We reach the transcendental 'we' by a conceptual self-projection scheme, from the 'here' of first-person awareness to the 'there' of the other (Scruton, 2004; Zahavi, 2003). This illustrates the fact that experience is itself belonging to the world and that our understanding the world is mediated. The transcendental subjective process is achieved by 'seeking to attain the genuine and true form of the things themselves' (Husserl, 1913, p. 119). That is, the pure ego and what it knows is the realm of transcendental phenomenology (Husserl, 1913). Kupers (2009, p. 54–55) stated, 'ontology is consequently founded upon epistemology, more precisely on transcendental subjectivity that is a reflection of the possibility for knowledge and experience'.

3.7.7 The Theory of Intentionality

Brentano's (1838–1917) theory of intentionality provided Husserl with a thematic insight into the nature of consciousness. According to Brentano (1874, p. 138), 'there is intentional content in all mental acts, including desires, hopes, expectations, and memories'. Conscious will 'is an illusion in the sense that the experience of consciously willing an action is not a direct indication that the conscious thought has caused the action' (Brentano, 1874, p. 433).

The goal of Husserlian phenomenology is the systematic description of the intentional experience. Husserl developed his phenomenological method to investigate and analyse the structures of meaning of a participant's intentional experiences. Husserl (1913, p. 262) believes that 'intentional experiences are unquestionably organised so that, given an appropriate viewpoint, a sense can be extracted from it'.

The notion of intentionality, in Husserl's phenomenology is based on the functional problem of the constitution of objectivities of consciousness (Husserl, 1913). However, consciousness is the core structure in Husserl's phenomenology. In Husserl's *Logic Investigation*, intentionality is secured; it is the most important element involving thoughts about objects. In philosophy, intentionality as a concept is used because it involves mainly human thoughts, such as beliefs and desires. It is the uniqueness of our self that characterises our desires to achieve our main goals (Berger, 1983).

The concept of intentionality is important to this research. Intentionality is also at the core of the religion of Islam. The literature review acknowledged the religious influences on the culture of Saudi society. Muslims live according to the Qur'an and they turn to the Hadith of the Prophet Mohammed (the second source of knowledge, derived from the Prophet's sayings) for guidance. The Hadith reports what the Prophet Mohammed said or approved of. One of the Hadith commonly reported by scholars of Islam refers to *niyah* (intention). Intention is a central concept in Islam. All actions are accounted for by the intention with which we do them (Audi, 1993; Berger, 1983; Powers, 2006).

There is a selection of scholars' commentaries on the narration of Umar Ibn Al-Khatab regarding the Hadith titled *Actions are but by intentions*. In this narration, Umar Ibn Al-Khatab noted that the Prophet Mohammed (PBUH) said:

'Action [deeds] are [a result] only of the intentions [of the actor],

and an individual is [rewarded] only according to that which he

intends. Therefore, whosoever has emigrated for the sake of Allah

and His messenger, then his emigration was for Allah and his

messenger. Whosoever emigrated for the sake of worldly gain, or a

woman [whom he desires] to marry, then his emigration is for the

sake of that which [moved him] to emigrate' [Narrated by Bukhari

and Muslim] (Fadel, 2009, p. 1).

Some Islamic scholars state that this narration is so central to Islamic belief

that it serves as an axis of Islam (Fadel, 2009).

The concept of intention involves all action, both voluntary and involuntary.

The scholar Al-Shafi'i was reported by Fadel (2009) as concluding that intention

comprises a third of all religious knowledge. According to Mattison (2008), the

intention is the goal or purpose we have in mind for doing an action. The intention is

the goal directing an action and making that action meaningful. Intentions not only

prompt actions, but they also make those actions intelligible or meaningful (Audi,

1993; Fadel, 2009; Powers, 2006).

The term 'niyyah' in the books of the scholars of Islam is used to distinguish

acts of worship (ibadat) from everyday matters (adat). This is important in

distinguishing an action that is performed for the sake of Allah, from an act done for

the sake of Allah as well as others, or just for the sake of others. If the intention

motivating the act is permitted, then the action is acceptable and the actor receives

neither reward nor punishment. Therefore, acts in themselves, whether they are

good, foul or neutral, are judged by religion according to the actor's intention (Audi,

1993; Fadel, 2009; Powers, 2006). Fadel (2009) claims that if the intention

motivating an act is good, then performance of the act is good and the person

receives his or her reward. As for the corrupt intention, the action it motivates is corrupt and the initiator of the action will be punished.

In phenomenology, every experience, or act of consciousness, is conscious. The subject experiences it and is aware of performing it (mental states that are not conscious are not the concern of phenomenology). Phenomenology also involves the notion that every act of consciousness is a consciousness of something. For example, in perception, I see the houses and the roads; in imagination, I imagine tomorrow or what I did yesterday; in judgment, I judge that my friend is a good person or that someone who harms me is a bad one. That is, most of our experiences take the form of a consciousness of something and all of our experiences in normal human life take their place in a structured, temporal stream of consciousness (Husserl, 1931, 1980).

A property of consciousness is that it is about being of or about something. Husserl called this intentionality. In phenomenology, the form of an experience is intentional or directed. It is intended or aimed towards some object (Berger, 1983; Husserl, 1931). Likewise, a mental state or act represents some object, such as an individual, an event or a state of affairs and so intentionality also comprises this representational character (Smith, 2007).

Smith (2007) claims that our acts of consciousness take their place within a matrix, or group of habits including bodily skills and even habitual background ideas. According to Brentano (1874, p. 138), 'there is intentional content in all mental acts, including desires, hopes, expectations, and memories'. Further, according to Brentano (1874, p. 433), conscious will 'is an illusion in the sense that the experience of consciously willing an action is not a direct indication that the conscious thought has caused the action'.

According to Husserl (1913), intentionality is a process in which the mind is directed towards objects of study. Every act of consciousness includes an object

'intentionally' within it. Husserl considers that the act itself is intentional to the object and viewed intentionality as the structural core of consciousness (Moran, 2000; Smith, 2003). Sadala and Adorno (2002, p. 283) state, 'the core of phenomenology is the intentionality of consciousness, understood as the direction of consciousness towards understanding the world'.

The significance of this concept is that intentional phenomena present the phenomena of interest in research, with the purpose of attaining the truth. According to Husserl (1913), the mind can focus on real objects that can be seen, touched and heard, or it can focus on images, concepts or memories. This selective attention involves choice and there is intention involved in making this choice and selecting the focus of attention.

Language, according to Husserl (1945), adds to intentionality. In this, he followed the traditional idea that 'language expresses thought' through the meaning of the sentences expressed. The production of language allows the utterances the possibility of expression of the consciousness. We express or utter the content or sense of our thinking. Every fact we experience has its object. In every experience and at every aspect of a special moment of life, we are consciously involved with objects. Two essential aspects of Husserl's concept of intentionality are 'noesis and 'noema'. Husserl (1913) states that every intentional experience has a *noetic* (real) phase and a noematic (non-real) phase. Every noetic phase of consciousness corresponds to a noematic phase of consciousness. Noesis is a process of reasoning, which assigns meaning to intentional objects. The functional of phenomenology in this logic, as opposed to the mathematical sense, is grounded in the pure essence of noesis (Smith, 2007). The function of intentionality is precisely that of constituting an object through 'noematic' sense (Husserl, 1913).

3.7.7.1 Noema and Noesis

From the theory of 'intentionality', Husserl adapted two distinct terms called 'noesis' and 'noema'. Their relation to conscious experiences and to the act of consciousness is important. Husserl describes how noesis and noema may be defined as phases of intentionality, describing the relation between consciousness and noematic meaning.

Husserl (1913) describes noesis and noema as two aspects of intentionality. He differentiates between the term 'noesis' (*cogitation*) and the term 'noema' (*cogitatium*), saying that noesis is distinct but inseparable from noema. Noesis is the process of cogitation, while the noemata (or *cogitata*) are that which is cogitated. The knower-in-act (cogitation) cannot be separated from the known act (*cogitata*) (Andrews, 2007, p. 118).

'Noema' is also referred to as 'noumena or 'noematic' which Husserl referred to as 'nucleus' as well as 'meaning' (Husserl, 1913). Adomo (1984), as cited in (Xian, 1993, p. 34), argued that Husserl's notions of the 'noesis' and 'noema' that constitute intentionality are the climax of the traditional Western philosophical idea of identity. He said Husserl believed that by apprehending 'noema', consciousness can discern absolute truth and secure eternal significance for its spiritual life (Husserl, 1913).

Noesis and noema may both be a means to explain objective meaning. The noetic meaning of transcendent objects is discoverable by reason, while the noematic meaning of immanent objects is discoverable by pure intuition (Husserl, 1913). Noetic meaning is transcendent, while noematic meaning is immanent. Thus, noesis and noema correspond respectively to experience and essence. The essential meaning of the noema is identified as a sense or noematic sense. It could embrace aspects of 'mind, insight, understanding, judgment and meaning' and was often used

in connection with making moral judgments (Husserl, 1913). The concept of 'noesis' is the constituting act in consciousness that generates meaning. Therefore, 'noesis' can give, adjust or reflect on the meaning of its objects. Further, these dimensions of meanings are not real, but are rather ideal elements in the flow of consciousness in life (Xian, 1993, p. 30).

Husserl says that the noema and noesis point to the connection between different perceived phenomena. Therefore, what is perceived is the noema (noematic) is the meaning of an intended act, but what is seen objectively to be evident is the noesis (noetic) is the intended act itself. Moustakas (1994, p. 29) states, 'For every noema there is a noesis; for every noesis there is a noema'. Moustakas (1994) claims that the uncovering and explication, the unfolding and becoming distinct and the clearing of what is actually presented in consciousness are said to be noematic. However, the process of uncovering intentions is known to be noetic (Berger, 1983; Husserl, 1977; Smith, 2003).

Noesis and noema, in Husserl's description, are both related to intentionality, or the direction of the mind towards a phenomenon. Noema is the way of describing the immediate phenomenon of seeing, say, a flower. The flower is not the phenomenon—it has a reality in and of itself. The phenomenon is what happens in the mind on seeing the flower; the immediate intuitive, pre-reflective response. Noesis in the other hand, is the conscious examination and description of one's experience of seeing the flower, which involves the bringing together of sensory data, previous experience and evaluation of similar phenomena, memory, social evaluations of such a flower, all of which allows the individual to identify a range of possible meanings for the experience. Both noema and noesis have to do with meaning. The issue that remains to be established is whether the experience of seeing

the flower has intrinsic meaning embedded within it, or whether meaning is only

attributed by the experience (Smith, 2007).

This point of reference involves the directedness of experience towards

things in the world and the inherited meaning within experience itself (Husserl,

1913). That is, consciousness is always consciousness of or about someone or

something (Smith, 2003). From the phenomenologists' point of view, our experience

is directed towards something through particular concepts, thoughts or ideas.

(Kupers, 2009; Smith, 2007). The intentional act is supposed to be related to the

world and its objects as every human being is related to what they belong to:

> 'The intentional relation was discovered within the context of
>
> consciousness, and it refers to the fact that consciousness is always
>
> consciousness of something and the object of awareness transcends
>
> the act in which it appears' (Giorgi, 1985, p. 50).

3.7.7.2 Conscious Experience: The World as Experienced

Phenomenology involves the issue of conscious experience (awareness). For

Husserl, phenomenology was to be grounded in the 'subjectivity' of experience, in

conscious awareness because that is where the truth and what is real is to be found

(Davidson, 2004; Smith, 2003). Phenomenology is an investigation that goes to the

fundamental structures of conscious experience (Thevenaz, 1962). Husserl argues

that there can be no experience—or, more generally, consciousness—without

objects. Consciousness is essentially of objects; it is essentially characterised by

'intentionality' (Smith, 2003; Smith, 2007; Berger, 1983). Whenever we experience

something, we show the characteristics affirmed of it (Russell, 1988), which Husserl

(1970, p. 308) calls 'the corresponding psychological facts in the context of human

consciousness'. These facts are due to our own nature, in our life-world (Russell,

1988, p. 85). Each 'corresponding psychological fact' is necessarily required 'to structure our experience, as a result allowing us to have empirical knowledge of the phenomenal world (the world as experienced)' (Law, 2007, p. 104).

Therefore, the process in this research investigation involved 'conscious experience'. Lived experiences involve the immediate consciousness of life's events prior to reflection and without interpretation and are influenced by those things that are internal or external to them (Husserl, 1913). According to Husserl (1970), not only is conscious experience naturally directed towards some object, but that consciousness also includes as 'inner insight' or 'perception' of the experience itself: a kind of secondary directedness of the mind towards itself. In this case, the theory of consciousness includes not only the theory of intentionality (how consciousness is a consciousness of something), but also the theory of inner awareness (how we are aware of being conscious of something). Husserl (1913) explains that consciousness is intentional insofar as it refers to, or is directed at, an object. Intentionality is a property of directedness towards an object. Consciousness may have intentional and non-intentional phases, but intentionality is what gives consciousness its objective meaning.

Conscious experience is the functional characteristic of consciousness that is capable of thinking, choosing or perceiving. In other words, consciousness refers to the mode of the mind, as an awareness of the feelings, thoughts and understandings of the surroundings (Gray, 2002; Husserl, 1913), while everyday experience is linked to it, as part of its life-world, which is the world of our consciousness.

As a research method, phenomenology emphasises the close relationship between primary awareness and sensory experience (Smith, 2007; Valentine, 1992). This relationship is important for the conduct of this research. Sensory experience involves the primary awareness of being conscious, so the contents of our primary

awareness are essentially sensory processing, while self-consciousness resides in the higher order in which one is aware of being conscious (reflective consciousness) (Smith, 2003; Valentine, 1992). Reflective consciousness is closely linked to our language and social life (Moustakas, 1994; Smith, 2007) and in phenomenology is typically 'intentional' (Valentine1992).

Perceptual experience is a visual consciousness, which has been subjected to epistemological understanding. Inquiry must concern always itself with pure seeing, rather than with the genuinely immanent (Husserl, 1964). Further:

> 'It is a mark of the type of Being peculiar to experience that
> perceptual insight can direct its immediate, clear and open gaze
> upon every real experience, and so enter into the life of a
> primordial presence. This insight operates as a 'reflexion', and it
> has this remarkable peculiarity—that which is thus apprehended
> through perception is, in principle, characterised as something
> which not only is and endures within the gaze of perception, but
> already was before this gaze was directed to it' (Husserl, 1913, p.
> 141).

The next section will describe the appropriateness of phenomenology as a methodological approach in relation to Islamic culture.

3.8 Phenomenology and the Saudi Culture

The Prophet (PBUH) said:

> 'Verily, knowledge is obtained by learning while understanding is
> obtained by experience. Whenever Allah wants to benefit a person,

He gives him understanding of the deed' (Narrated by Al-Tabarani,

260–360 AH, as cited in Yakan, 2002, p. 16).

It is the aim of phenomenological reduction to uncover the intentional

meaning of a subject, a concern shared by Islamic culture. The concept of

intentionality in phenomenology is theoretically similar to the Islamic system of

intentional law (maqasid al-Shari'ah). This system was developed by jurists and has

been called 'usul al-fiqh' (the base, or root, of jurisprudence), referring to its aim of

deriving the law from its source (Al-Hayani, 2005, p. 572). The concept of the

intentional law originated in the Holy Qur'an. It comprises a set of principles that

address changing conditions (Al-Hayani, 2005; Al-Zabi, 2000; Dhanani, 1993;

Powers, 2006).

In respect of the intentional experience of any subject, all phenomena must

be considered with regard to the concepts of benefit (*maslahah*) and harm

(*mafsadah*) (Attia, 2008). If the intentional act contains more benefit than harm, the

act must still be considered beneficial (Al-Ghazali, 1963). Al-Hayani (2005, p. 573)

cited Khadduri (1984) to say that the scholars of Islam believe that:

'Benefits should take priority over a textual source, given that the

Islamic law (Shari'ah) was laid down to protect the public interest

which is the ultimate purpose of the Divine Legislation.'

According to Al-Hayani (2005, p. 573–574), the intentional law of Islam

(*maqasid al-shar*) is rooted in the two concepts of intention (*maqasid*) and benefit

(*masalih*). In addition, Al-Hayani points out that the steps of Islamic intentional law

adhere to ethical premises in the Holy Qur'an and delineate the path to be taken to

alleviate deficiency, disease and unhappiness in the world, and to promote wellbeing,

good health and success. Scholars agree that the intent of the law as well as the

public interest should be seriously considered in the process of arriving at any legal opinion. The concept of benefit has been designed to address one essential and basic point: consideration and protection of the necessities of human life (Dhanani, 1993; Powers, 2006).

As Saudi nurses, it is our duty to be responsible for changing and improving the conditions of nursing. In addition, Muslims should do what they can to maintain and improve the nursing profession in Saudi Arabia. Islam does not ask that individuals are exclusively text-oriented in understanding this world, but value-oriented also, and this should drive our actions in the life-world. Islam asks us to observe, think and reflect, and not just to copy others.

If we do not think about the nature of caring on which our actions are based, and if we do not think about the nature of being a Muslim, then we misunderstand what it means to be a Muslim, and more specifically, a Muslim nurse. It is also important to see that nursing, as a caring profession, has never been opposed to who we are as Muslims, whether we are male or female.

3.9 Conclusion

It is important for the researcher to explore methodology, as the assumptions behind it shape the research. Phenomenology is known to be a branch of philosophy concerned with the theory of knowledge and it has been very influential as a qualitative research methodology. Phenomenology as a paradigm of thought searches for truth and for objective knowledge. Husserl's phenomenological method is concerned with the absoluteness of our consciousness and the way things are perceived through it.

Using phenomenology as the methodology for this research demonstrates a commitment to Husserl's insistence on the need to open up the narrowed mind. As a

result of Husserl's efforts, a new horizon of research has arisen under a new

paradigm of consciousness (thought)—all related to intentionality and evidence of

intuition. Husserl's idea of a transcendental subjectivity highlights the centrality of

human beings, the language we speak and the cultural influences on this language.

Husserl's research and contributions to phenomenology also point to the uniqueness

of the individual.

Phenomenology as a research methodology involves the use of unique

scientific processes. The methods proposed by Husserl use rigorous tools, designed

to promote objective thinking about all the aspects of the phenomena of interest, not

just particular aspects. Phenomenology is characterised by the view that a whole

system of belief must be analysed, rather than only its individual components.

Husserl proposed phenomenological methods to understand the essence of

phenomena. He spoke of transcendental experiences and considered these to be

going beyond the facts regarding a subject to truly understand that subject.

The nursing profession is governed by the principles of science and its key

theoretical assumption is based on a belief in the nature and reality of caring.

Nursing as a concept of caring has been broadly supported by the scientific methods

of modern research. In this research, the notion of the lived experiences of nurses

and their interaction with our surrounding world, and the idea of our self-

conceptualisation, is very relevant to me as a Saudi nurse and a Muslim. I am

saddened by the thought that the Saudi nursing profession may be dysfunctional and

I believe the nursing profession in Saudi Arabia should not be less than other

professions, which often have clear concepts of what that profession involves. These

concepts are essential, with each culture displaying different concepts that influence

their members' faith, thinking, understanding, learning and descriptions of

phenomena (Husserl, 1970).

The importance of utilising concepts from the natural sciences lies in the capacity of these concepts to search out the experiences of people's lives. These concepts relate to the conviction that all actions are constructed on foundations of consciousness or original perception of some phenomenon. The phenomenon, fact or observable facts in natural science are mathematically measurable, with the tools for describing them initially based on descriptive methods.

Husserl (1913) held that only through meaning does consciousness present us with a world and organised structure of things around us. That is to say, the main concern in phenomenology is a focus on analysis and understanding the meaning of experienced phenomena, to structure phenomenological concepts (Husserl, 1970).

From a phenomenological standpoint, my concern in this research does not lie with finding the truth of my experience of being a Saudi nurse, but it lies with the importance of truth as it is experienced by Saudi nurses as a group. Therefore, I need to clarify the meaning of their lived experiences, with the understanding that in this phenomenological research there can be no further reasonable question of whether the meaning proposed by Saudi nurses is true.

The methodology, as I have just described it, leads to the method, and this will be discussed in the next section.

Chapter 4: The Research Method

4.1 Introduction

While the methodology is the philosophical framework that underlies this project, the method is the means by which the project is undertaken. This research aims to uncover the experience of being a Saudi nurse, and reveal the needs Saudi nurses have, based on their understandings of their development and practice as nurses. Phenomenology was employed as the methodology to approach, identify, describe and understand the Saudi nurses' lives as they live and experience them (Crotty, 1996). Research based on the nurses lived experiences has been conducted to identify the hidden meanings of such experience (Sokolowski, 2000).

The possible role of phenomenology in research has often been debated, but few firm conclusions have been reached. In its current state, phenomenological research involves systematic approaches that often reflect the rigour of the scientific method (van Manen, 1990), even though the research methods have varied in the way philosophical principles are applied to develop them (Rapport & Wainwright, 2006).

Nursing research has highlighted and acknowledged the value of phenomenology as a philosophy, as a methodology and as a research method of inquiry that could provide an understanding of the individual's reality and experience (Ray, 1994 van der Zalm & Bergum, 2000; van Manen, 1997). Polit and Beck (2006, p. 219) state that 'phenomenological beliefs are critical truths about reality and are grounded in people's life experiences'. Phenomenology has been used extensively in nursing research to explore the meaning of the phenomena of interest. Further, it is an appropriate method of research when the meaning that the phenomenologist requires is embedded in the lived experience and not fully

apparent: when there is 'a need to understand the social, cultural and experiential aspects of a particular aspect of human existence' (Jackson, Daly & Chang, 2003, p. 143). This is particularly important for my research because the objective information I am seeking can only come from understanding the context in which Saudi nurses live and work. It can only come from a phenomenological research method. In the words of Bowling, '"reality" is socially constructed through the interaction of individuals and their interpretations of events; thus the investigator must understand individuals' interpretations and experiences' (Bowling, 2002, p. 19).

Phenomenology offers suitable methods to describe the phenomena of the lived experience and increases our understanding of the characteristics of an individual's reality. This is usually inadequately understood both holistically and contextually (Holloway & Wheeler, 2002; Jackson, Daly & Chang, 2003; Rapport & Wainwright, 2006). In general, nurses experience their work as a learning environment (Skår, 2010) and phenomenological research can provide added insight (Cohen & Omery, 1994; Kahn, 2000a; Polit & Beck, 2006). Therefore, phenomenological research is a useful method to choose when exploring a new area, when a new insight is needed on a topic that has already been explored (Cohen, 1994; Stuart, Parker & Rogers, 2003; Willis & Grace, 2011) or when researching a phenomenon for the first time, as was the case in this particular research.

This chapter details the phenomenology that is used in this research, the goals of the research, the different phenomenology schools and the influence of hermeneutical phenomenology on the framework of this research.

4.2 Phenomenology: Its Use in This Research

Phenomenology as a research method was used for two key reasons. First, phenomenology had the potential to establish a legitimate knowledge of the Saudi nurse's experience. Secondly, phenomenology is considered to be based on intentionality and intentionality is the core of Islam, making it appropriate for the cultural context in which it was to be applied. As described in the preceding chapter, phenomenology is rooted in the philosophical assumptions about experience, intention, truth, the relation between known and knower and the way knowledge is acquired and formed.

This research involves nurses currently practicing, as well as those who have left nursing. Those nurses who have left the profession may also have valuable experiences and insights to share. This is, perhaps, essential for the professional development, practice and career opportunities of nurses. Through their experiences of being nurses we can come to understand their practical concerns and the needs of their profession.

4.3 Phenomenology as a Research Method

Husserl's phenomenological methodology involves a systematic investigation of the structures of consciousness. Husserl offered phenomenological concepts as a way to understand the essence of phenomena, through 'transcendental' experience (Smith, 2007).

As a research method, phenomenology is devoted to describing the structure of experience (the sum total of the things that have happened to participants) and of past thoughts and feelings as they present themselves to consciousness without theorising and making assumptions about what is being presented. Both Husserl and Heidegger have emphasised aspects of our historical consciousness, in which:

'Consciousness is both presupposed by, and revels [in] reality. In order to reach *zu den Sachen selbst* (to the things themselves), it is necessary to pursue the phenomenological method of reduction, a graded series of alteration in perspective' (Valentine, 1992, p. 177–178).

Husserl's method acknowledges that consciousness can refer to objects outside of itself (Kupers, 2009; Smith, 2007). Consequently, as we experience phenomena relating to those objects, we experience them in our consciousness—we experience them in different ways, but it is in our consciousness that we experience them and it is in our consciousness that they are viewed and stored. In view of this, phenomenology as a method is intended to investigate conscious experience by analysing the structure of various forms of experiences (Kupers, 2009, p. 55). Phenomenology practiced within a human science perspective can produce valuable knowledge about individuals' experiences.

The main task of phenomenology, according to Husserl (1917, p. 3):

'Is to investigate something perceived or pictorially represented and investigate how it looks by virtue of that grantable of sense and of characteristics which is carried out intrinsically by the perceiving or by pictorial representing.'

Holloway and Wheeler (2002) argue that Husserl attempted to construct a comprehensive description of the phenomenon of everyday experience to achieve an understanding of its essential structure by using a descriptive phenomenological method. The methods in Husserl's descriptive phenomenology involve four steps: 'bracketing, intuiting, analysing and describing' (Polit & Beck, 2004, p. 253), all of which are based on the interpretation of the lived experiences. Phenomenology as a

method, according to Husserl, is to study what appears to the mind, in the act of self-conscious reflection (Husserl, 1980; Scruton, 2004). For example, Husserl (1913) maintains that natural objects must be experienced before any theorising about them can occur. Spiegelberg (1971, as cited in Valentine, 1992, p. 178) distinguishes three stages in this investigation:

- Intuiting: intense concentration on and attentive internal gaze at phenomena;

- Analysing: finding the various constituents of phenomena and their relationships; and

- Describing: providing an account of intuited and analysed phenomena such that they can be understood by others.

Phenomenological research has hypothesised that meaning can arise from collective lived experience (van Manen, 1990). Fay and Riot (2007) point out that phenomenology has treated the issue of meaning not from the perspective of a philosophical system, but rather from that of a method that aims at re-establishing a genuine connection with the world-of-life that each of us can experience in our daily life.

According to Giorgi (1997), phenomenology as a research method offers an important focus of conscious experience in all its varieties, 'for investigating the structures of consciousness and essences' (Kupers, 2009, p .55). One useful aspect of the phenomenological method is that it describes particular phenomena in their contexts, or the appearance of particular things, as lived experience (Carpenter, 2010).

The importance of phenomenological research lies in the meaning of lived experience (Beck, 1994; Crotty, 1996; Ray, 1994; van Manen, 1990). Phenomenologists advocate the interpretation of textual material obtained while

talking with people or through observation (Madjar & Walton; 1999; van Manen, 1990). Walton and Madjar (1999) point out that a phenomenological inquiry often begins with an exploration of the subjective experience. It is for this reason that recorded interviews are important for phenomenological research.

Kupers (2009, p. 55) explains that a phenomenologist separates how phenomena are experienced from how they appear in a subject's consciousness 'for investigating the structures of consciousness and essences'. Once we examine evidence, we discover objects, but we also discover ourselves—precisely as datives of disclosure—as those to whom things appear (Sokolowski, 2000). Sokolowski argues that we are not supposed to think only about the things given to us in experience, but 'we can also understand ourselves as thinking them' (2000, p. 203).

4.4 Approaches within Phenomenology

Within one methodology there can be many methods (Richards & Rodgers, 2001) that utilise different approaches. Richards and Rodgers (2001, p. 19) point out that 'an approach is a set of correlative assumptions dealing with the nature of the text to be considered'. In addition, they argue that an approach is axiomatic: it describes and caters for the nature of the subject matter to be taught (Richards & Rodgers, 2001; Zahavi, 2003). Phenomenology as a research method is not an approach, but requires a set of approaches to carry it out. These approaches must emphasise the connection between the research and the researchers (van Manen, 1990). Three main issues are involved in phenomenological research: the nature of the subject matter (metaphysical assumptions), the nature of scientific theories (theoretical assumptions) and the nature of observations and experimentation (methodological assumptions).

Based on the chosen methodology, there are important epistemological and ontological assumptions. Essential to this is the fact that the research requires a relationship between the knower and the known (Poole, 1975; Porter, 1996; Roger, 2008). The connection between philosophical assumptions, the concept of the social reality and the true nature of knowledge that exists in our life-world is central. A major aspect of phenomenology is the nature of language and the way analysis is carried out. To research is to obtain knowledge, in particular objective knowledge (Tilley, 2004). Therefore, verbal communication is the starting point of phenomenology; the analysis and interpretation of the participants' interviews is secondary.

Phenomenological research is a theory-based research methodologically. In this research, the design includes six research activities that must be used alongside each other, with each activity focusing on a different aspect of the research aims in regard to collecting and analysing the data. Each activity involves different methods and techniques and is essential in achieving the main goal of this research.

4.5 Goals of Phenomenological Research

Phenomenology aims not only to describe the meaning of the lived experience, but also to understand the basic structure of the meaning—the essence of phenomena—through understanding each experience of the participants in relation to the context in which these experiences occur (van Manen, 1990). This understanding must proceed from the meaning of each experience to avoid approaching the lived experienced of the participants from the perspective of the researcher, who is detached from the sense of the whole of the experience of the participant who lives it (Giorgi, 1985; Sokolowski, 2000).

To understand the world is to be in the world and to be in the world is to know more fully the world in which we live as human beings. From a phenomenological point of view, we have an inseparable connection to the world, which phenomenology calls intentionality (van Manen, 1990), because the meaning that phenomenologists strive to capture involves the conscious experience of the intentionality that lies behind the act of consciousness (Husserl, 1913). As mentioned in the proceeding chapter, every act of consciousness includes an object intentionally within it.

The focus of phenomenological inquiry is the experience of the everyday life—the life-world of our experiences. Van Manen (1990) identifies the factors involved in phenomenological research. According to him, phenomenological research is:

- The study of lived experiences.

- The explication of phenomena as they present themselves to consciousness.

- The study of essences.

- The description of experiential meanings as we live them.

- The human scientific study of the phenomena.

- The attentive practice of thoughtfulness.

- Research for what it means to be human.

- A poetising activity.

The main goal of a phenomenological research methodology is to describe, analyse and interpret the meaning through which individuals identify a certain phenomenon. Sokolowski (2000, p. 203) argues that we should not think only about the things given to us in experience, but 'we can also understand ourselves as thinking them'. This sort of understanding is the focus of phenomenology. In the

context of this study, the understandings drawn about the reality of what it means to be a Saudi nurse are based on (and conscious of) what the data represent and what they means to the researcher.

4.6 Husserl's Phenomenological Method

Husserl (1931, p. 209) states that phenomenology:

> 'Aims at being a descriptive theory of the essence of pure transcendental experiences from the phenomenological standpoint, and like every descriptive discipline, neither idealising nor working at the substructure of things, it has its own justification. Whatever there may be in "reduced" experiences to grasp eidetically in pure intuition, whether as a real portion of such experience or as an intentional correlate, that is its province, and is a vast source of absolute knowledge for it.'

4.6.1 Phenomenological Reduction

Husserl (1913) describes how phenomenological reduction may be used as a method of philosophical inquiry. He explains that the method of phenomenological reduction is a process whereby empirical subjectivity is suspended, so that pure consciousness may be defined in its essential and absolute being. This is accomplished by a method of bracketing. Bracketing empirical data away from further investigation leaves pure consciousness, pure phenomena and the pure ego as the residue of phenomenological reduction (Smith, 2003).

'Phenomenological reduction is enquiry within the sphere of pure evidence. It is enquiry into essences' (Husserl, 1990, p. 7). From an empirical point of view, Husserl (1913) believes that phenomenology cannot proceed until mental

phenomena have been separated entirely from residual beliefs about the physical world. Therefore, we cannot start analysing the data until we detach our beliefs from the data or the physical world (Husserl, 1948). Therefore, Husserl argues, we must undertake a phenomenological reduction. This involves 'bracketing, disconnexion or cancelling the reference to external things, so as to confront the pure phenomenon' (Scruton, 2004, p. 243).

Phenomenological reduction, according to Husserl (1913) is the process of defining the pure essence of a psychological phenomenon. Husserl (1990) claims that phenomenological reduction is an essential element of the Cartesian method of doubt, as a method of enquiry assumed to discover the reality, the relative truth. Husserl (1964, p. 7) states:

> 'The root of the matter, however, is to grasp the meaning of the absolutely given, the absolute clarity of the given, which excludes every meaningful doubt, in a word, to grasp the absolutely "seeing" evidence which gets hold of itself.'

In this research, the phenomena of interest needed to be perceived and presented as it is experienced. Its real nature is required for the investigation. For conducting a phenomenological analysis, according to Husserl (1970, p. 308), we need to give a descriptive analysis of the essence of the act of which we are self-evidently aware. Through Husserl's process of holding the intentional experience lightly, a researcher strives to move 'from external existence to a transcendental attitude' (Husserl, 1913, p. 110). This attitude involves the technique of bracketing in which the researcher is required to 'put out of action the entire ontological commitment that belongs to the essences of the natural attitude' (Husserl, 1913, p. 111). This technique was used in this research.

4.6.2 The Technique of Bracketing

Bracketing refers to judgment. It is a technique by which the researcher suspends their judgment by distancing their own preconceptions, beliefs, ideas, values and attitudes from the task of understanding the phenomenon at hand. In nursing research, it is by bracketing suppositions that we reduce personal judgments concerning the lived experienced of being Saudi nurses.

In Husserl's phenomenology, the concept of epoche is important. Bracketed judgment is an epoche or suspension of inquiry, which places in brackets (or sets aside) whatever knowledge belongs to essential being. According to A. D. Smith (2003), the epoche is nothing but reflection, or reflexivity, carried through from a true philosophical basis. Moustakas (1994, p. 26) states, 'epoche requires the elimination of suppositions and the raising of knowledge above every possible doubt'.

Bracketing requires locking empirical intuitions away from philosophical inquiry. Husserl (1913) argues that bracketing is a neutralisation of belief. 'One can without further ado abstain from any judgement, that is, one can put … performance out of play for certain particular purposes' (Husserl, 1954, p. 240). Researchers do this by refraining from making judgments to reject or eliminate their own intuitive bias. In phenomenological reduction, 'we do nothing but clearly formulate and develop consistently what was always … We part company in this connection with psychologistic interpretations of evidence in terms of feelings' (Husserl, 1990, p. 7).

The technique of bracketing is especially important in allowing essences to emerge (Husserl, 1913). According to Husserl (1931), it is necessary to bracket the presuppositions that one holds about the world. In addition, he highlighted the concept of bracketing to describe the structures of the world as experienced rather than as assumed.

It has been suggested that the researcher may already be well informed about the research topic based on his or her own understandings and assumptions (Laverty, 2003). However, one of the problems identified in phenomenological inquiry is that of having too much information prior to conducting the interviews and obtaining the data for the analysis. In phenomenological reduction, the researcher must assume that their attitudes, beliefs or prejudices may influence the accuracy of the research investigation (Cohen, 1987). Reduction as a method is the process of looking at the experience truthfully, without the preconditions, prejudices or biases that one usually brings to any description.

As discussed previously in this chapter, Husserl (1913) maintained that it was possible for the researcher to suspend or bracket their beliefs. However, Heidegger (1962) believed that it was impossible to totally bracket one's experience. He contended that it was too difficult to ignore what was already known. Further, he argued that it would enhance the research if the researcher made explicit their own understandings, beliefs, biases, assumptions, pre-assumptions and theories (Heidegger, 1962). Essentially, Husserl and Heidegger are describing the same process: a process concerned with truth. The notion of bracketing is important in allowing essences to emerge (Husserl, 1913). Husserl highlights the concept of bracketing to describe the structures of the world as experiences, rather than assumptions. Koch (1995, p. 829) states that:

> 'Husserl insisted on an initial "suspension of belief" in the "outer world", either as it is naively seen by an individual in everyday life, or as it is interpreted by philosophers or scientists. The "reality" of this outer world is neither confirmed nor denied; rather, it is "bracketed" in an act of phenomenological reduction.'

Phenomenological reduction by bracketing aims to eliminate bias (Rose et al., 1995). Phenomenological reduction brings the researcher closer to what the subject's consciousness intended, with even intuition playing a role to obtain the essence of meaning (Smith, 2007).

Sokolowski (2000) points out that transcendental reduction should not be seen as an escape from the question of being or the study of being. Sokolowski (2000) argues that when we shift from the natural attitude to the phenomenological, we raise the question of being, because we begin to look at things precisely as they are given to us, precisely as they are manifested, precisely as they are determined by 'form', which is the principle of disclosure in things. In this case, Sokolowski (2000) states, 'we begin to look at things in their truth and evidencing. This is to look at them in their being' (Sokolowski, 2000, p. 203).

Husserl's technique of bracketing is designed to turn attention from the objects of consciousness to consciousness of those objects. It turns attention to the way those objects are experienced and then to their essence in reality.

4.7 The Influence of Hermeneutical Phenomenology on the Research Framework

'Two embedded assumptions of hermeneutics are that humans experience the world through language and this language provides both understanding and knowledge' (Byrne, 2001b, p. 968).

The methodological framework adapted to human scientific research by van Manen (1990) has influenced the framework of this research inquiry. Van Manen's phenomenological methodology has contributed to this research as a guiding framework. It is discussed in detail in the next chapter.

4.7.1 Hermeneutics: An Interpretative Approach

Hermeneutics as a research approach is a way of systematically dealing with interpretations. The hermeneutic phenomenological approach is used in this research to facilitate the descriptive method of phenomenology.

In the human sciences, researchers and philosophers generally seek to understand the action of people through dialogue, with their words being understood as the words of self-discovery, motivated by reason (Scruton, 2004). However, for this systematic inquiry, two central issues concerning the theory of textual interpretation are considered: the text (its meaning) and the interpretation (understanding).

Hermeneutics is concerned with the way we come to understand. It explores and involves all the processes of communication, including reading, writing and listening (Thiselton, 2009; van Manen). Valentine (1992) points out that the data of social science is already partially interpreted and that the role of the researcher is to identify the meaning of an action in terms of the role it plays in the social situation. The emphasis is on structure and explanation of the parts by reference to the whole; explanation is nothing other than clarification of this structure, as a constituent element (Gadamer, 1975; Valentine, 1992). This empathic understanding leads to a more modern form of research for the social sciences. By probing the concept of the hermeneutic approach, Ray (1994, p. 118) concluded that:

'The hermeneutic-phenomenological tradition or interpretative approach is a way of being in the social-historical world where the fundamental dimension of all human consciousness is historical and sociocultural and is expressed through language.'

Gadamer (1975) initiated the concept of the hermeneutic circle through the original work of Schleiemacher and Dilthey (Annells, 1996). Gadamer's exploration of the theory of language also places an emphasis on the language that we speak and its history as vital contributions to the hermeneutic circle (Fleming, Gaidys & Robb, 2003; Koch, 1996; Lebech, 2006). In philosophy, three themes in hermeneutic inquiry have always been present, namely: 'the inherent creativity of interpretation, the pivotal role of language in human understanding, and the interplay of part and whole in the process of interpretation' (Smith, 1991, p. 104).

Historical consciousness for Gadamer was a sympathetic form for knowledge and understanding (Gadamer, 1975). Gadamer, like Husserl, argues that the task of hermeneutics is not to offer either a methodology or method of understanding, but rather it is to 'clarify the conditions in which understanding takes place' (Gadamer, 1975, p. 263). However, since our experience and knowledge are connected to phenomena, such phenomena are certainly things that appear in our consciousness. 'In the search for certainty, it is natural to begin with our present experiences, and in some sense, no doubt, knowledge is to be derived from them' (Russell, 1988, p. 7).

Hermeneutics as an interpretative method is recognised as a philosophy that emphasises an approach to health research that focuses on meaning and understanding in context (Hadderton, 2004; Charalambous, Papadopoulos & Beadsmoore, 2008; van Manen, 1997).

4.7.2 Hermeneutic Phenomenology as a Research Approach

Based on the framework of phenomenological research, van Manen (1990) developed a methodological structure for research that is both phenomenological (descriptive) and hermeneutic (interpretive). His approach stresses the importance of the relationship between phenomenology, hermeneutics and semiotics in research

(Ray, 1994, p. 122). Van Manen (1990, p. 2) described hermeneutic phenomenology as a research methodology relevant to human science. He claims that, 'human science' is often used interchangeably with the terms 'phenomenology' or 'hermeneutics'.

Hermeneutic phenomenology represents the main theoretical assumptions about experience and ways of organising and analysing phenomenological data. It gives equal weight to both ontological and epistemological concerns and promotes the unity that must exist between the researcher as knower and the things or objects that the researcher comes to know (Moustakas, 1994, p. 44). Such phenomenological research is theoretically designed to investigate the phenomenon of interest and analyse and interpret the essences without predetermined assumptions or hypotheses about problems or ideas that have no fixed expressed value (Munhall, 1994; van Manen, 1990).

According to van Manen (1990) hermeneutic phenomenology is concerned with understanding texts and tends to focus more on accounts of the phenomena obtained from written texts. In the search for the lived experience of the subject, the hermeneutic approach requires reflective interpretation of a text to achieve a meaningful understanding (Moustakas, 1994). Therefore, it is important to complete all transcriptions before undertaking any theorising, which would, at that point, be based only on partial facts about the lived experiences of Saudi nurses.

Hermeneutic phenomenology as a research design theoretically fits my research, since the interpretations must be understood in context (Ray, 1994; Sokolowski, 2000; van Manen, 1997). The everyday experience of the subject and the researcher are part of this context (Ray, 1994; van Manen, 1990). In the search for the lived experience of the subject, the hermeneutics approach requires reflective interpretation of the experiential content to achieve a meaningful understanding

(Moustakas, 1994; Ricoeur, 1986). As part of the data analysis, the researcher aims to create rich and deep accounts of the lived experiences with the assistance of intuition, while focusing on uncovering rather than accuracy, and amplification with avoidance of prior knowledge (Ray, 1994; Sokolowski, 2000; van Manen, 1990). In this research inquiry, the hidden meanings of phenomena in the lived experiences of Saudi nurses are uncovered, so that they can be interpreted to reveal what being a Saudi nurse means.

4.8 Conclusion

Phenomenology is central to this research project. It provides the methodology—the rationale—behind the research as well as the method for conducting the research.

Hermeneutic phenomenology represents the main theoretical assumptions about experience and offers approaches to organise and analyse phenomenological data. The importance of phenomenological research lies in the meaning of lived experience and it is only phenomenology that can adequately describe the phenomena of the lived experience of Saudi nurses.

Phenomenological research includes special methods, techniques, steps and research activities. These activities require the collection of data from documents as well as from participants. Collecting data from participants involve interviewing, recording, listening to and transcribing the phenomenological data.

The approach and method used in qualitative research inquiry involve both 'textual' and 'contextual' construction. They emphasise both the narrative (storytelling) and semantic (relating to meaning) approaches within a theory of context. Therefore, phenomenology as a qualitative method, offers the possibility of understanding the data of the lived experiences of Saudi nurses. As a descriptive

method used for research, phenomenology, with the use of hermeneutics, can strengthen the relationship between the researcher and subject and allow the voice of the subject to be heard.

Modern phenomenological thought has been influenced by science and guided by its method. Van Manen (1990) combined features of descriptive phenomenology (Husserl's perspective) and interpretive phenomenology (Heidegger's view) to develop hermeneutic phenomenology. Hermeneutics as a research technique is adopted in this research as a way of systematically dealing with interpretations of the meaning of being a Saudi nurse. For example, in textual interpretation, hermeneutics searches for meaning within the context of this research.

Phenomenologists agree that researchers cannot grasp the meaning or the sense of the whole of given experiences by separating the parts from the general context in which every part is based. To address this, hermeneutics emphasises understanding the basic structure of meaning—the essence of meaning—through understanding each experience of the participants (the parts) in relation to the context in which these experiences occurred (the whole). In phenomenology, this understanding is necessary to avoid approaching the lived experiences of the participants from the researcher's perspective, which would be detached from the sense of the whole of the experience for the participant who lived it.

As phenomenology requires reflection, phenomenology as a descriptive method and hermeneutics as an interpretative approach are both valid for this research. This is particularly important in relation to the hermeneutic phenomenological method's capacity to allow researchers to reflect sympathetically on belief in the context of the researchers' culture, through the method of phenomenology described earlier in Chapter 3. In this way, phenomenology helps the researcher understand the uniqueness of the phenomena that represents the

essence of being a Saudi nurse. With the presence of intelligible concepts (the secondary concepts), the method of phenomenology offers the possibility to expose understanding of the Saudi nurses' lived experiences in the context in which they live and work.

Such phenomenological research is theoretically designed to investigate the phenomenon of interest without predetermined assumptions or hypotheses about research problems or predicted concepts concerning the phenomena under investigation. Phenomenology promotes the view that a whole system of beliefs must be logically analysed. Each part needs to be fully understood and related to the whole. This has led to hermeneutic phenomenology being selected as the method according to which this research was designed. The resulting research design is detailed in the next chapter.

Chapter 5: Research Design

5.1 Introduction

This chapter provides an overview of the research design and research process and is divided into two main sections. The research framework is highlighted in the first section (see Section 5.2), while the second section demonstrates the approach and procedures chosen to collect and analyse the data (see Section 5.3). A description of the participants and ethical considerations applied in this research will follow. The chapter concludes with an explanation of the criteria used to evaluate the research.

5.1.1 Experiential Context

The context in which Saudi nurses live their experiences is influenced by such factors as culture, history and religion. In phenomenology, the research inquiry necessarily involves the phenomena of our beliefs and desires as Saudis and Muslims, and, in the context of this research, of being a Saudi nurse. The context of this research is significant for understanding the findings of the research. As the researcher, my knowledge enables a first hand understanding of the lived experiences of being a Saudi nurse. The experience is not transformed through another cultural lens, as would occur if an expatriate conducted this research.

Van Manen's (1990) approach to phenomenological investigation provides a means of obtaining reliable information about the phenomena of interest and requires the researcher to ask those who have had those experiences (Edwards, Cable, Williamson, Lambert & Shipp, 2006; Wong & Lee, 2000). The participants chosen include nurses currently nursing, as well as those who have left nursing. It was supposed that those nurses who had left the profession would have had valuable

experiences and would be able to offer insights into their reasons for leaving, helping the researcher determine whether the experiences of ex-nurses have any relationship to the experiences of nurses currently practicing. Such an exploration can enhance our understanding of what is meaningful to Saudi nurses: what are their expressed needs and how do they reflect and interpret their experiences. This research will also be a beneficial addition to the growing body of literature on recommended organisational policies and practices for improving the profession of Saudi nurses.

Musker (2011) confirms the importance of narrative in exploring nursing practice. He illustrates the importance of the narrative approach and the paradigm of thought for developing personal and professional awareness of theories that harmonise with one's worldview. The benefit of independent nursing practice according to Musker, is to enhance understanding of meaning. This will contribute to closing the gap between theory and practice (Musker, 2011).

5.2 Research Framework

Hermeneutic phenomenology provides a design framework for this research. This framework is described below, along with a description of van Manen's six steps of the methodological structure of hermeneutic phenomenological research. The six research steps that van Manen (1990, pp. 30–31) identified are:

- Turning to the nature of lived experience.

- Investigating experience as we live it rather than as we conceptualise it.

- Reflecting on the essential themes that characterise the phenomena.

- Describing the phenomena through the art of writing and rewriting.

- Maintaining a strong and orientated relation to the phenomena.

- Balancing the research context by considering parts and wholes.

In this research investigation, phenomenology is the journey towards self-knowledge, the knowledge of the lived experiences of being a Saudi nurse. The research design of this research inquiry has evolved from the theoretical frameworks described in the philosophical underpinning of phenomenological research (van Manen, 1990). As a methodological framework, hermeneutic phenomenology values the ability of the researcher for self-knowing and allows the participants to give voice to their experiences in an open manner (Robertson-Malt, 1999).

Phenomenological analysis is continual in that as one writes the results, often more is revealed through the writing process (van Manen, 1990). This requires an immersion in the data, which is achieved by repeated listening to the original recorded interviews as well as writing and reading the transcripts (Beck, Keddy & Cohen, 1994; Kahn, 2000b).

Van Manen (1997a, p. 31) described the 'doing' of phenomenological research and writing as 'a dynamic interplay between six research activities'. As indicated above, these activities will guide the investigator through this research. These dynamic research activities are adapted in this research to facilitate the entire structure of research design, including the approaches used to collect the research materials and the methods undertaken to describe, analyse and represent the findings in this research. By following these six steps, Saudi nurses' lived experiences and perceptions of being a nurse can help the researcher to uncover an understanding of the meaning of their experience.

5.2.1 Turning to the Nature of Lived Experience

Van Manen (1997a) proposed that the starting point of phenomenological research is mostly a matter of identifying what it is that interests the researcher and acknowledging this interest as a true phenomenon. To focus on the research question

of understanding the lived experience of Saudi nurses, the aims of this research have been phenomenologically developed, as explained in the prologue.

Uncovering the lived experiences of the Saudi nurses can only be done through in-depth interviews, with the cooperation of Saudi nurses, and their sharing of their needs and what they feel. The value of this sharing lies in the nature of their unique lived experiences as nurses; their perceptions regarding the nature of their nursing tasks in which they have learned, observed, practiced and experienced nursing; and how they have communicated these experiences with other nurses in everyday communication. It is the researcher's judgment that it is the voice of the Saudi nurses themselves that needs to be heard for their situation to be improved.

5.2.2 Investigating Experience as We Live It rather than as We Conceptualise It

Van Manen (1997) believes researchers need to study experience as if they are living it rather than simply observing it. This supports the concept of being-in-the-world and allows the researcher to understand the nature of Saudi nurses' lived experiences and reveal the essence of those experiences. In this research, I seek to understand the experience of my subjects' being-in-the-world as Saudi nurses, a world I know intimately. Lived experience is different for everyone and we all have had unique experiences that we can reflect on and share (Morley and Ife, 2002; van Manen, 1990). As van Manen says, 'a lived experience has a certain essence, a "quality" that we recognize in retrospect' (van Manen, 1990, p. 36).

If lived experience is the accumulation of the past as well as present experiences that shape all characteristics of our being-in-the-world, then the question of 'what is it like' to be in the world must be based on these experiences. As a research method, it requires a hunger on the part of the researcher for awareness and the will to seize the meaning of the world as that meaning comes into being. In other

words, phenomenology does not produce empirical or theoretical observations or accounts. Instead, it offers accounts of experienced space, time, body and human relations as we live them. Husserl's method of phenomenology is a special type of first-person reflection on experience in which we develop phenomenological descriptions of key forms of consciousness.

My life has been spent immersed in Saudi culture and Muslim beliefs. I have my own understandings and theories that relate to this research, such as about the role of women in Saudi society, the role of Muslim teaching and the nature of Saudi nursing. Therefore, there is opportunity for me to be influenced by my own biases. Van Manen (1990) refers to the necessity of the researcher's general knowledge of being-in-the-world, which includes the researcher's pre-understanding of the topic under investigation. However, to learn the most from this research project, I personally need to suspend my general knowledge, 'deliberately holding it at bay and even to turn this knowledge against itself, as it were, thereby exposing its shallow or concealing character' (van Manen, 1990, p. 47).

Husserl (1913) argues that it is necessary to bracket the presuppositions that one holds about the empirical world. In addition, he highlights the concept of bracketing to describe the structures of the world as experiences rather than assumptions—as we live it rather than as we conceptualise it. He says:

> 'We put out of action the entire ontological commitment that belongs to the essences of the natural attitude, we place in brackets whatever it includes with respect to being' (Husserl, 1913. p. 111).

I have needed to put aside, to 'bracket' away, my attitudes and my own experiences in regard to the opinions of the nurses interviewed. Where I have disagreed with their views and where I may dispute the information they provide, I

have told myself, at the time of interviewing, transcribing, translating and analysing the results, that my aim is simply to understand. The process of bracketing is essential so that the data are genuinely the lived experiences of the nurses interviewed. In phenomenological research, there is no room for the biases of the researcher, no room for the researcher's own understanding, except in situations that it allows for empathy towards or understanding of the subjects. This is why this process is called bracketing, because it sets aside understanding—the understanding of the researcher—to be used only at the appropriate time.

Bracketing takes some practice. I do not want to see the world through someone else's eyes, hear it through someone else's ears or think about it with someone else's thoughts. For the purpose of this research, I want to understand and think as Saudi nurses do.

The suspension necessary for Husserl's bracketing involves our judgment. As a researcher I use my judgment not to deny the knowledge I have, but to simply set it aside and not make use of it. This means that I do not judge. I suspend judgment for the sake of recording the participants' descriptions of their experiences, thoughts and perceptions. I do this suspension intentionally, as I listen to, read and write the participants' stories.

Afterwards, once the lived experiences have been recorded, as I listen to the interviews again or read the transcripts, I attend not just to what the participants talk about, but to my understanding of them, being careful not to judge. At this point, I use every resource I have to better understand the lived experience of Saudi nurses. This is the point at which I interpret their meaning. From understanding the lived experience of the participants, I move to writing and talking about these experiences. Consequently, I shift my attention from my consciousness of what the participants have expressed, to my consciousness of what they mean.

The phenomenological method is designed to understand the human life-world, to give a deeper understanding of the nature or meaning of our everyday experiences and to generate insightful descriptions of the way we experience the world (Cohen, 1987; van Manen, 1990). In this research, as soon as the phenomenological description is carried out, the phenomenological method is used to merge the participant's statements about what it is to be a Saudi nurse. This allows the researcher to structure the data into manageable categories and provides a means by which the investigator can discover and present the reality of the participants' experiences (Madjar & Walton, 1999).

The technique of phenomenological reduction applied in this research seeks to increase the researcher's understanding of the subjects' experiences by aiming to eliminate bias (Rose et al., 1995). Through phenomenological reduction, I became aware of what it is like to be a Saudi nurse through others' lived experiences. As Cohen & Omery (1994) suggested, through the method of reduction, I intentionally looked at the lived experiences naively without involving my pre-understanding, preconditions, prejudices or biases that one usually brings to any situation.

5.2.3 Reflection on the Essential Themes Which Characterise the Phenomenon

In searching for the lived experiences of a subject, a hermeneutic approach requires reflective interpretation of a text to achieve a meaningful understanding (Moustakas, 1994). Meaning is the core of phenomenological research. Therefore a phenomenological design is most appropriate in this research for acquiring and collecting material that explicates the essences of Saudi nurses' lived experiences.

The lived experiences of Saudi nurses are initially described in written form for the researcher to refer to (or reflect on). As part of the process of data analysis, the outcome of this phenomenological description is a series of general statements

about the phenomena. This becomes a reflection of all of the specific experiences of the participants. Van Manen (1997, p. 79) referred to phenomenological themes as 'the structures of experience'. Robertson-Malt (1999) stated that decisions about essential and non-essential themes are made by the researcher relying upon the context of the interpretation. Therefore, the researcher is occupied with the reflective activity of textual work (van Manen, 1997) using three approaches to uncover thematic parts in the participants' descriptions. These approaches are: the holistic approach, the highlighting approach and the detailed or line-by-line approach (van Manen, 1990). The essential themes are those statements made by Saudi nurses that can be used and interpreted for the purpose of understanding the lived experiences of Saudi nurses. These essential themes could indicate necessary improvements in nursing.

I have consciously tried not to prejudice the research with my personal observations and views. As the researcher, my background assists me in understanding the meaning of the lived experiences of being a Saudi nurses from different perspectives, helping me to arrive at the essential themes and generalisations as a result of things seen and experienced (Madjar & Walton, 1999; Sokolowski, 2000).

5.2.4 Describing the Phenomenon through the Art of Writing and Rewriting

Hermeneutic phenomenology is concerned with understanding texts and tends to focus on accounts of the phenomenon obtained from written texts (van Manen, 1990). According to van Manen (1990), writing and rewriting in hermeneutic phenomenology enables the researcher to remain aware of the way language speaks, the transcribed interviews become the phenomenological text upon which the method of hermeneutic analysis is made, and the writing and rewriting

activity provides the stage upon which the researcher can communicate and evaluate the themes (van Manen, 1997).

The transcribed interviews became my texts. These I then broke down into many meaning units (an independent unit of information). From these, I identified themes and began collating these according to the meaning units. This dynamic approach led to an understanding of the essential themes to come out of the research. All this is done within the framework of frequently stepping back to explore the overall design and structure of the research. Phenomenologists agree that the first characteristic of the phenomenological method is that the analysis and interpretation of the texts has to follow the descriptions given by the participants, instead of being given an explanation from the theoretical standpoint of the researcher (Giorgi, 1985; Aanstoos, 1985).

Phenomenological writing concerns both the process and result of phenomenological inquiry. The researcher writes to represent the phenomena of the lived experiences as well as to describe to others the findings of the research inquiry. Through the method of phenomenological reflection, the researcher seeks to determine the essence of the lived experience (van Manen, 1997).

In this research I listened to the interviews and read both the Arabic and the English versions of the transcribed interviews. I checked, to the best of my ability, the translations from Arabic to English and systematically investigated the research questions by interpreting the participants' perceptions, allowing the meaning of their experiences to be understood. As themes developed, I began searching the transcripts again, writing and rewriting to describe the meaning and give sense to the relation between the phenomena under investigation.

5.2.5 Maintaining a Strong and Orientated Relation to the Phenomenon

    Hermeneutic phenomenology is concerned with the way we understand. It is the basis on which understanding is possible and explores and involves the entire process of communication (Thiselton, 2009, p. 2). All aspects of the subject's thoughts and experiences are considered as well as being viewed as comprising a whole (Smith, 2007).

    According to van Manen (1997a), it is essential that the researcher reflects on the phenomenon being studied throughout the research. By the use of bracketing, I remained oriented to the phenomena under investigation, helping me to understand the phenomenon as a whole and 'not settle for superficialities and falsities' (van Manen 2001, p. 33). This is in line with Islamic teaching in which the main aim of logic is to obtain reliable knowledge. The Holy Qur'an mentions three basic organs through which reliable knowledge is obtained; these are: eyes for seeing, ears for hearing and heart for understanding:

> 'Allah brought you out of your mothers' wombs in such a state that
> you knew nothing. He gave you ears, eyes, and hearts, so that you
> may be thankful' (Qur'an, 16/78).[14.]

    In phenomenology, being conscious is considered to be the natural human state. Phenomenology as a research method challenges me to become more conscious of my own life-world and better able to explore and understand it. In phenomenology, the ability of consciousness to understand the life-world is intentional and I am aware of the need to be intentionally honest and rigorous when seeing, listening and feeling how others experience the life-world. It is important for

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[14] The Qur'an, (1989). Surah al-Nahl, (16/78). (Arabic version, Translated by Yusuf Ali) Saudi Arabia: The Holy Qur'an Complex in Madinah.

me as a Muslim to be conscious of the presence of our life-world. With time, I have

been better able to understand and explore my life-world and equate it with the

experience of being a Saudi and a nurse.

5.2.6 Balancing the Research Context by Considering Parts and Wholes

The analysis of the material collected in this inquiry includes an

interpretation of aspects of language to show the intent of a subject's words. This

involves the researcher's focus on an understanding and explanation of the parts of

the text, as well as joining them together as a whole (van Manen, 1990). In the

hermeneutical sense, meaning is captured from within the text. The concern of

hermeneutics is not in what the text describes (explains or explicates) but it is what

the text reveals (what we understand) (Ray, 1994; van Manen, 1990). The emphasis

is on structure and explanation of the parts by reference to the whole; explanation is

nothing other than clarification of this structure, as a constituent element (Gadamer,

1975; Valentine, 1992).

I adopted the essential hermeneutic principle that, in carrying out this kind of

research, one cannot escape from the problem of the hermeneutic circle; that is, to

understand the part, it is necessary to know the whole, while at the same time

understanding that the whole depends on an understanding of every part. The

advantage of using a phenomenological method for this research is that the

researcher is part of the research, and is better placed to understand the parts and

give sense to the whole experience as revealed by the participants (Kupers, 2009;

Sokolowski, 2000).

This dynamic approach has led to an understanding of the essential themes to

come out of the research and has shaped the structure of the next chapter, which

outlines the findings. In the discussion chapter, I will reveal the essences of the

research findings and summarise the main points, including recommendations for the future. All this is done within the framework of frequently stepping back to measure the overall design and structure of the research.

5.3 The Research Process

5.3.1 Organising Research Questions and Ethical Considerations

In phenomenological research, the research question is asked with the aim of knowing 'the nature of the given forms of lived experience' (van Manen, 1990, p. 42). Therefore, the researcher first must know 'what it is like to be' for those particular lived experiences. Achieving reliable information about the phenomena of interest requires researchers to ask those who have had that experience.

The phenomenological question is often unstructured. It is usually an 'open-ended' question that allows the researcher to listen to his or her subject—in this case to Saudi nurses—feel their experience and search for meaning in their lived experiences. It allows the researcher to become one with the experience (van Manen, 1990).

Tools used for this type of inquiry include participant invitations (see Appendix A for the English version and Appendix B for the Arabic version), explanatory statements (see Appendix C for the English version and Appendix D for the Arabic version), consent forms (see Appendix E for the English version and F for the Arabic version) and an interview guide (see Appendix G for the English version and H for the Arabic version). For the purpose of this research, these resources were designed in English and then translated into Arabic for the Saudi-speaking nurses through an official translation office.

Ethical approval was obtained from Monash University Human Research Ethics Committee (MUHREC) (see Appendix I) and from the Ethics Department of the MOH in Saudi Arabia (see Appendix J) before the commencement of this research. Ethical principles became important guidelines in this research inquiry and the guidelines provided by the National Statement on Ethical Conduct in Human Research (2007) were used with consideration of the religion of Islam and the Saudi culture.

5.3.2 The Beginning of the Research Journey

Prior to commencing the journey and starting the interviews for data collection, a period of interview training was undertaken with my supervisor. This consisted of discussions on the differences between a clinical interview and a phenomenological interview. Other issues discussed included the preparation of 'setting aside self' and the importance of asking questions to assist the participants in deconstructing events.

The next stage involved being an observer during a phenomenological interview conducted by the supervisor, followed by a discussion on the processes used. I was then required to interview the supervisor on a 'safe' topic, in this case the experience of being a grandmother. Feedback was given on technique and body language.

The next step was to practice my interviewing skills. I used the research questions in interviewing a friend with the supervisor present. This was useful, enabling me to improve my interviewing and data collection techniques. Once I felt comfortable and prepared for phenomenological interviews, I returned to Saudi Arabia to conduct them.

5.3.3 Gender Issues in Conducting the Research

It should be noted that in line with Islamic beliefs, female participants were interviewed by a female interviewer trained in phenomenological interview techniques. This interviewer was a professional social worker who had experience with qualitative interviews. She was trained by me in Saudi Arabia using the methods suggested by my supervisor. Criteria for asking a phenomenological research question and intentionally setting aside self and own experiences were established and applied across the participants' interviews. These included being able to engage with female participants with different nursing experiences and backgrounds and being able to deal with sensitive issues in an empathetic and non-judgmental manner.

5.3.4 Participant Selection and Sample Criteria

Researchers need to choose who to interview, what the nature and purpose of the interview will be and where and how the interview is best conducted. Through purposive sampling methods, the researcher chooses the most appropriate participants for the conduct of this research. I used a purposeful sample (Streubert & Carpenter, 1995), based on the area of interest (Llewellyn, Sullivan & Minichiello, 2004). The principles of participant selection and how these apply to this research are discussed below.

5.3.4.1 Inclusion Criteria

Participants were Saudi nurses currently working as nurses and Saudi nurses no longer working as nurses who met the criteria of having a minimum of five years' experience as a nurse. This is based on the concept that expertise is acquired after working in similar situations for five or more years (Benner, 1984). Any Saudi nurse who met these requirements was considered as a potential participant.

5.3.4.2 Exclusion Criteria

Excluded from this research were expatriate nurses and newly graduated Saudi nurses as well as Saudi nurses lacking the required experience. The next section will describe the process of data collection and the approach used to collect the research data.

5.4 Data Collection

The research data were collected by means of in-depth interviews. The interviews were conducted between November 2007 and January 2008. To collect the richest data, the participants for the research inquiry were located at different sites and came from various specialised areas in nursing care practice, as recommended by O'Brien (2003). The interviews were conducted at a time and place convenient (and appropriate) for each participant. Below, the conduct of the interview will be highlighted and issues relating to the data analysis will be discussed, before biographical details of the participants are given in the next section.

5.4.1 Recruitment Strategy

It is a requirement of the Saudi government that all research is approved by the relevant ministry. A letter was sent to the MOH, applying to the Ethical Department in the Ministry for approval to undertake this research. It should be noted that nurses working in Ministry hospitals have been instructed not to take part in research that has not been approved by the MOH. The letter sent to the MOH outlined the proposed research, including explanatory statements and a consent form. The application was approved (see Appendix I). Official letters from the Ethical

Department in the MOH were forwarded to announce the research to Saudi nurses in the KSA with the cooperation of the General Health Directorates in each region.

Efforts to recruit to the research through the MOH were ineffective. A visit to each region to follow up the official letters sent by the MOH was organised. A notice about the research was placed on the local nursing website, accessible by all nurses. This resulted in responses and led to a snowball effect. Using this approach, nurses from different regions and from a variety of nursing educational backgrounds were recruited. MUHREC was notified about the changes. In total, 17 Saudi nurses (from five regions in Saudi Arabia) participated and were interviewed. A detailed description of these participants will be presented in Section 5.5.

5.4.2 Research Setting and Participants

Five regions of Saudi Arabia (including the Western, Eastern, Central, and Northern regions) were represented in the data by the participants. These regions, locations and the number of participants from each are summarised in Table 5.1. The distribution of the participants is presented in Table 5.2.

Table 5.1

Regions, Locations and Number of Participants

Regions	Location (City)	No. of Participants	
		Male	Female
Eastern	Dammam	-	1
Northern	Hail	1	-
Central (Qassim)	Buraidah &	2	5
	Unaizah	-	2
Central (Riyadh)	Riyadh	1	4
Western	Madinah	1	-
Total		5	12

Table 5.2 shows that four of the 12 female participants were not currently working as nurses, while three of the five male participants were not practicing. The age of the participants ranged from 24 to 47 years and their experience in nursing practice ranged from five to 25 years.

Table 5.2

Distribution of Participants

Participants	Group A (N=10)	Group B (N=7)
	Practicing the Nursing Profession	Working in Other Unrelated Area
Male	2	3
Female	8	4
Total	10	7

5.4.3 The Interview: Its Structure and Conduct

The most common method used by phenomenologists is the unstructured or semi-structured interview (Bowling, 2002; Wimpenny & Gass, 2000). Balls (2009) points out that the unstructured interview may be the gold standard in phenomenological research, with advanced listening skills guided by the principles of understanding (Munhall, 1994). In this research the interview was semi-structured so that the participants could express their experiences of being a Saudi nurse. This allowed the researcher to deconstruct their lived experiences and their concerns. Allowing Saudi nurses to share their experiences through the recorded interviews brought to the fore the reality of their lived experiences and was successful in achieving the main goal of understanding the meaning of the lived experiences of Saudi nurses.

5.4.3.1 The Structure of the Interview

Interviewing is a method of discourse that involves consciousness and which allows researchers to understand the most difficult issues concerning cultural, social and educational subjects (Ray, 1994; Williamson, 2002). The interviews were conducted in Arabic and recorded.

The nature and culture of being a Saudi complicated this technique in that there is an underlying suspicion of a person asking questions. The issues appear to be founded in who will be told about the interview and whether the content of the interview might be used against the person being interviewed. This required a modification of the interview technique in that the interviewers needed specific questions at hand in case the interviewee became tentative. Further, the interviewers reassured the participants that they would be de-identified and that there were no feedback mechanisms.

5.4.3.2 The Conduct of the Interview

Before the interviews were carried out, consent forms were signed by each participant. The details of the process of the interview were explained and all participants were informed that the interview would be transcribed and a copy could be given to them. Prior to each interview, I 'set aside self' (van Manen, 1990), or bracketed, intentionally setting aside my own experiences and suspending my own beliefs 'in order to achieve a fresh perspective based on data collected from persons who have experienced the phenomenon' (Ary, Jacobs, Sorensen & Razavieh, 2006, p. 473). Each recording was labelled with a code, which was tagged to the notes taken for each interviewee. More detail on this particular technique will be highlighted in the discussion of the data analysis presented below.

5.4.4 Data Analysis: Interpretation and Translation Issues

All the dialogue from the interviews was transcribed into written text. The Arabic transcriptions were then translated into English for the purpose of research analysis and confirmability. The quality of the translation mechanism plays a significant role in certifying the results obtained (Maneesriwongul & Dixon, 2004; Wen-Ling, Hwei-Ling & Fetzer, 2006). To determine that the English interpretation conveyed the same meaning as the statements in the Arabic version, the English translation was retranslated into Arabic and compared with the original Arabic version of the interviews.

Comparison between the original and back-translated versions is necessary, as is comparison between the English and Arabic language versions (Chang, Chau & Holroyd, 1999; Tang & Dixon, 2002). Back-translation gives an assurance that the meaning in the text is the same in the two languages, providing an indication of reliability of the target language version (Chang et al., 1999). In the case of this research, the results were good, but not excellent. There is a significant discrepancy between how the two languages function and, in many cases, it was impossible to translate accurately from one language to the other, especially if there was no equivalent meaning or word representation corresponding to the grammatical style of the Arabic language.

This is a similar situation to that found by other researchers in non-English speaking countries such as China and Japan (Chang, Chau & Holroyd, 1999; Koide, 2006; Tang & Dixon, 2002). Researchers from these countries have found differences when translating the qualitative data from their native language to English. Fortunately, these differences did not impact upon the overall analysis or interpretation of their research findings. For example, Twinn (1997), when

translating Chinese qualitative data to English, found no significant effect on the analysis of the results.

In this research, and in phenomenological research in general, it is important to note that the researcher is not required to translate the meaning of each word in Arabic independently to understand the participant's statements. What is required is an interpretation of the meaning of the participant's statements. Therefore, with the help of notes I made at the time of the interviews regarding the subjects and their general attitudes and experiences, the English translations were very close to the exact meaning of the Arabic words spoken by the participants.

Each interview was transcribed then translated separately and saved in word documents. As the process of interpretive analysis rests with the researcher, a process of listening, reading and reflection was required to elicit the themes. During the initial analysis, the tapes (of the interviews in Arabic) were listened to many times, providing an immersion in the data. During this time, themes began to emerge and an overall impression of the experience of being a Saudi nurse began to take shape. Once the themes had been identified in Arabic, the English translation took place. This maintained the integrity of the analysis by eliminating one source of data loss (Koidi, 2007).

The major emerging themes were discovered through repeated empirical and reflective analysis of the interview audiotapes and transcripts. The initial themes were chosen while working in Arabic and were then checked for credibility by an experienced Arabic-speaking researcher. This procedure was carried out to protect and preserve the findings before they were translated into English. This process is common in hermeneutic phenomenology (Kahn, 2000).

5.5 The Research Participants

Seventeen Saudi nurses were interviewed. Each participant's experience is unique, yet all the participants in this research share similar thoughts and experiences. They have expressed similar perceptions and ideas, all based on shared cultural beliefs and the logic of Islam. As a result, the uniqueness of each participant's experience reveals a shared reality among Saudi nurses. The participants, who have been given a pseudonym to protect their identity, are introduced below.

5.5.1 Ahmad

'I was ignorant of what nursing really is.'

Ahmad graduated from a HI in 1991. He worked for 10 years in different areas including health care centres, hospitals, a psychiatric hospital and a geriatric hospital. He also has experience working as a nurse in different regions, including Qassim, Riyadh and Dammam. Ahmad has now left nursing and is working in the department of Medical Records.

Ahmad did not plan to become a nurse. He had been cared for by foreign nurses, both male and female, but did not think he would become a nurse. He said, 'I didn't know anything about nursing. It was new to us'. He only learned about nursing when he attended an information session at the HI. At that time, he was at intermediate school and was being encouraged to join the HI after graduation. He chose to study nursing at the HI for four reasons. He said:

'It was near to my house, we received a monthly salary during study, study was easy because it had fewer subjects compared with

secondary school and nursing offered the chance for continuing

study.'

When he joined the HI, he encountered difficulties with the study. Ahmad

felt no desire to continue studying and left for three weeks, but his father and several

colleagues encouraged him to return. By the time he passed the first year, he felt that

nursing was 'strange', and that it was not compatible with the Saudi culture, customs

and traditions. He said he learned very little. Further, he remarked that the study was

in Arabic, despite the fact that practicing as a nurse required using English. He said

that the teaching of English at the HI was not sufficient.

Ahmad described nursing as a compassionate profession and said that when

he was practicing nursing, he enjoyed working in the Primary Health Care Centre

(PHCC). He said:

> 'The role of the nurse in the health centre is a vital one, due to its
>
> close contact with society. The presence of Saudi nurses in the
>
> PHCC facilitates receiving care, specifically for the old ones'
>
> [people].

During the interview Ahmad spoke openly about his experience as a nurse.

He revealed many aspects about nursing and society's attitude towards nurses. He

also shared his feelings about the difficulties Saudi nurses faced. His experiences as

a nurse were challenging. He said:

> 'When someone asks me about my job, I used to answer that I am a
>
> government employee because I felt contempt and valueless when
>
> I said I was a nurse.'

Ahmad did not leave nursing because he did not want to be a nurse. He wanted to do further studies at a health college. However, after enrolling in the health college, family reasons prevented him from continuing his studies. He was then requested to work outside of nursing. He said, 'I wish and hope to [return to] work as a nurse and serve with my hands'. If he found adequate support he would 'return strongly without any hesitation'. 'Nursing as a caring profession was considered the first occupation in Islam', he explained. Ahmad described the concept of nursing as 'a humanitarian job [which] includes rewards if the nurse accounts his work for the sake of almighty Allah'. He is considering returning to the job and working as a nurse in a PHCC.

5.5.2 Ali

> 'Thanks be to Allah, nursing provides a good opportunity for work
> and one has to utilise these chances'.

Ali graduated with a diploma from a HI in 1993. After graduation, he worked for five years as a nurse. His experience in nursing includes working in both PHCCs and in a hospital. He worked for more than three years as an orthopaedic nurse and experienced many challenges in the practice. He pointed out that nursing taught him many things and one of the good things that he learned was the English language. He said:

> 'Being in the hospital and having the desire to learn helped me in
> learning the language. To participate and work in the field of
> nursing you have to be good at English, especially in speech,
> because if you do not speak good English you will not be able to
> participate.'

Ali is no longer practicing nursing. After developing good English communication skills, he accepted an opportunity to work in another department. Ali observed that some of his colleagues who graduated with him did not practice nursing but were working in Hospital Administration. 'This encouraged me to transfer to an administrative job', he said.

Before becoming a nurse, Ali had no plans to study nursing and no clear ideas about the task of nurses: 'We didn't know the real role of the nurse'. He acknowledged his friends who convinced him to become a nurse: 'My friends advised me to join the field of nursing and I studied it and graduated'. Ali felt that he had never regretted working in nursing. He said he benefitted from his work in nursing as nursing was helpful to his career and useful in his family life. He said, 'Thanks be to Allah, nursing provides a good opportunity for work and one has to utilize these chances'.

Ali's experience reveals many points that are relevant to this research inquiry. His story gave an account of his experience with nursing education, practice and administration. He highlighted the impact of these major components of the nursing profession on the Saudi nurse's performance. He links these to the lack of suitable nursing training programmes and to the lack of guiding principles to follow in both education and management. Further, he clearly described the attitude of society and expressed some important issues related to the Saudi nurse's position. Ali didn't feel he had benefitted from the nursing programme. When he graduated he realised that, 'there was no one qualified to train the new graduates'. However, Ali gained some skills through his participation in nursing practice.

Ali feels that the work environment of Saudi nurses does not consider the conditions and situation of the Saudi nurses. He said that male Saudi nurses who work in the hospital faced difficulties because their practice involved working with

foreign women, which our society does not allow. He pointed out the impact of the

attitude of society on the choices of nurses, both male and female. Further, he

stressed the importance of nursing education for qualified Saudi nurses. He said:

> 'Nurses can change society's opinion of nursing by being
>
> dedicated to their work. By doing their work perfectly, they will
>
> give a good image to the Saudi nurse.'

5.5.3 Khalid

> 'The Saudi nurse needs to be confident because no one will benefit
>
> a country except that country's own citizens'.

Khalid studied at both a HI and a health college. He completed the

requirements of the HI in 1987 and in 1998 obtained his qualification from the health

college. Like Ahmad, Khalid has experienced a variety of nursing situations,

including health care centres, hospitals, a psychiatric hospital and a geriatric hospital.

He also holds a position in the administration of the PHCCs. He has 19 years'

nursing experience. Currently, Khalid is no longer practicing nursing. At the time of

the interview, he was working in the Patient Affairs Office at one of the hospitals.

Khalid decided to study nursing at a HI because 'studying nursing at that

time was the only opportunity for me to find a job'. Further, he said, 'my thinking

was only on getting a job'. Like Ali, he did not have any background in nursing. He

expressed viewpoints similar to the other participants about there being no

information about nursing and its study. Khalid pointed out that he didn't have any

idea about what nursing was like as a profession or about its significance in serving

society. He had no desire to become a nurse, but it became an opportunity available

to him after he had completed elementary school. He chose to study for three years and quickly obtained qualifications and a job.

After practicing as a nurse he has come to recognise that nursing is a humanitarian and social service. While continuing his nursing education at the health college, he discerned the differences between the nursing programmes at the HI and the health college. He said:

> 'During my study in the College I felt that I learned much because
>
> the teaching language is English and the knowledge base of the
>
> subjects was higher than it was in the HIs.'

Khalid's experience demonstrates the difficulties Saudi nurses face. He indicated the need to improve the nursing profession and he explained why Saudi nurses leave the practice. He expressed dissatisfaction with the nursing education system and management's policy and also revealed the problems nurses face because of the views of society. Further, he outlined the influence family can have on those who are considering nursing as a career.

Khalid pointed out the main problems faced by Saudi nurses. He said:

> 'Our main barrier upon our graduation from the HI was the
>
> language … always there is a barrier for us with writing and
>
> reading, which requires English.'

He believed Saudi nurses were unable to master the English language and that language is the main barrier preventing nurses from practicing in hospitals. When he was first employed, he was fearful of working as a nurse due to his lack of ability to communicate and because of a lack of proper skills. He suggested that the HIs prepare or qualify Saudi nurses to work only at a PHCC, rather than in hospitals.

Khalid explained that if he was encouraged to return to nursing, he would use his experience to improve the status of Saudi nurses. He thinks the experiences of Saudi nurses need to be made known so change can take place. He stressed that Saudi nurses should have the opportunity to exchange experiences with colleagues so that all nurses, including newcomers, can help each other. Khalid told of how important the job of the nurse is, 'If a nurse does their work for God, then God will never frustrate his or her hopes'.

5.5.4 Waleed

> 'We lack plans because we lack the competent people who are able
>
> to develop nursing.'

Waleed has completed qualifications from a HI and a health college and he recently obtained a nursing degree from Australia. He has worked as a nurse for five years in hospitals, including in the intensive care unit (ICU), the emergency room (ER) and in medical and surgical units. He is now a Nursing Supervisor in the emergency department of a hospital.

Waleed said that his father helped him to become a nurse. He said, 'My father believed that nursing was a good field'. Like Khalid, he said nurses do not struggle to find a job. Further, he explained that he didn't have any background in nursing, but that he went into nursing with the main aim of finding a good job.

He believed that he has gained significantly more knowledge by continuing his nursing education. He said, 'What I have learned makes me know the importance of developing nursing and improving the present status of Saudi nursing'. His experience of studying abroad made him realise the weaknesses of the educational standards prescribed for the Saudi nurse at the HIs and Colleges. He now believes

the nursing profession in Saudi Arabia does not have the resources to raise the standard of nursing skills in the Kingdom.

Waleed points out the different aspects of the nature of the problems associated with nursing practice and their links to the lack of suitable management. Similarly, he shared many views about the role of nursing management and the education system. He revealed that the objective of the MOH was only to open institutes and to increase the number of graduates and that no attention was paid to academic performance.

He said, 'now there are more male nurses, most HIs have been closed, and replaced by health colleges'. He mentions the difficulty faced by Saudi nurses, especially females. He said, 'the problem is that the number of Saudi female nurses is still insufficient due to obstacles and difficulties facing women in this field, which are related to mixing with males and the attitude of the society'.

His emphasis was that the nursing profession in Saudi Arabia lacks plans for nursing. He said, 'we lack the competent people who are able to develop nursing'. Only when nursing administration has plans and strategies will the situation get better, he added. Further, Waleed stressed the need for Saudi leaders who are able to effect change and development.

5.5.5 Sami

> 'The problem is too big to be solved … unless the status of the
>
> Saudi nurse is improved'.

Sami received a diploma from a HI in 1992 and has been working as a nurse in a PHCC for more than 15 years. Sami has worked in different clinical positions including at general hospitals, a psychiatric hospital and a geriatric hospital. Like other male participants, prior to studying at the HI, Sami did not have any

background in nursing. His main understanding about nursing was that nursing was the work of foreigners and this was only because of the large number of foreign nurses in the field. His friends encouraged him to study nursing. He followed their counsel and joined the HI. He said, 'I heard that the study at the HI is simple and there is a salary which students receive during study and after graduation the job is guaranteed'. These were the main reasons for him joining the HI.

Like the other interviewees, Sami did not benefit from his study at the HI. As he said, 'It was not enough'. When he passed the first year, he thought of changing his course due to the nature of the nursing tasks, but then he became more familiar with the tasks and decided to continue studying nursing. He pointed out that the study at the HI was not difficult, but the difficulty was in applying it. He explained that one of the problems he and other Saudi nurses faced was that nursing was not accepted by society.

Further, he explained why he preferred working in the PHCC; he did not feel that he was able to work in nursing until he practiced and he expressed that when he worked at hospitals he faced the problem of communicating with foreign nurses. At the PHCC, it was easy for him to practice because the main language used was Arabic. The nature of the work in the PHCC helped Sami to accept nursing and made him feel that his skills were enough for his role as a nurse in the PHCC.

Sami pointed out that he and other Saudi nurses were not prepared to work in a new environment such as a hospital and stressed that few opportunities were given to him and to other nurses. He said, 'we [Saudi nurses] were even marginalised'. In addition he highlighted that the situation for nurses is not the same as before, some of the new nurses are enthusiastic about work and the attitude towards the Saudi nurse has started to improve. However, the professional status of the Saudi nurse has not yet improved. He expressed his feelings and said Saudi nurses will not be

happier in their work, 'unless their status is improved'. If the situation remains as it is, he added, many nurses will continue to leave nursing for other jobs in which their status is higher. All the nurses that Sami knows are disappointed, they do not like the present situation and are thinking about leaving the profession. Further, according to Sami, 'most nurses are influenced by other nurses who left nursing'.

Sami said, 'The problem is too big to be solved.' For him, retirement is the solution. 'I am thinking of early retirement—in three years—God willing'.

5.5.6 Imtinan

'The nursing image must be changed so society can accept the profession.'

Imtinan is a female Saudi nurse who graduated from a HI. She is no longer working as a nurse. Her love and interest in nursing as a career gave her the motivation to continue with her profession for almost 15 years. Like other participants who graduated from HIs, Imtinan faced many difficulties. In the interview, she revealed that her problems involved 'mainly understanding the language of other nurses'.

Imtinan pointed out that those who graduated from HIs like herself lacked the ability to help and encourage each other because they did not know enough. Imtinan's experiences were similar to those of the other nurses interviewed. She also shared a similar viewpoint on 'how the public perceived female Saudi nurses'. The problem, she said, 'is that the community does not know the real and true role of the nurse.' She said mixing did not occur in nursing, but she rationally explained the influence of this matter on the Saudi female's lack of preference towards nursing as a career. In the interview, Imtinan argued that 'the long working hours have had a negative effects on the married life of Saudi female nurses and on their children'.

She also stressed the lack of incentives available to nurses and states that she had experienced a lack of support from the nursing administration.

Further, she commented that the nursing administration did not concern itself with the working conditions of Saudi female nurses because most of the nursing managers were expatriates. In this regard, she felt that as a female Saudi nurse, she was not important. Imtinan revealed there was a need for encouragement as well as training to allow Saudi nurses to improve their skills. She said nursing management needed to pay attention to the long working hours that made the life of Saudi nurses hard to endure. She said, 'The nursing image must be changed so society can accept the profession'.

5.5.7 Zainab

> 'Nursing is a great humanitarian work … It is not my decision to leave nursing practice but the decision came from the Hospital Administration.'

Zainab is a female Saudi nurse. She graduated from a health college and worked as a nurse for five years. She was interviewed in the hospital at which she worked, although no longer in a nursing capacity. Zainab stopped nursing because the hospital administration needed her to do another job. It was not her decision to leave nursing practice and she would still be willing to practice her profession. She said 'I still want to be a nurse'.

Zainab did not want to be a nurse at first. Instead, she wanted to study at the University of Medicine. However, she was not able to study there because it was too far from the city in which she lives. Her father did not want her to travel, so she decided to attend a College of Nursing with some of her friends. As with other participants, Zainab liked being a nurse, stressing that 'nursing is a great

humanitarian work'. When she started practicing as a nurse, she was the only Saudi female nurse working in the hospital.

In the beginning, as a new employee, Zainab encountered problems in dealing with patients and working with expatriate nurses. She was not able to understand the expatriate nurses' language and this made her feel stressed and uncomfortable. She reported not having had the support that recent graduates required. As she did not know much English, she could not understand her duties as a nurse and often found instructions ambiguous.

Further, she faced many difficulties outside of the hospital, because her relatives objected to her being a nurse. This was mainly because they were opposed to mixing.

5.5.8 Sarah

> 'Most of the people did not really understand the work of nurses
>
> and its relation to Islam.'

At the time of interview, Sarah had been working as a nurse for more than five years. She graduated from a health college and is now a head nurse. Sarah was interviewed at her hospital. She said that she started considering becoming a nurse during high school. Sarah admired the work of nurses when she visited a friend who was in hospital. She said, 'when I go to the hospital and see the doctors and nurses helping patients I wanted to be like them'. This gave her a strong motive to become a nurse.

Like other participants, when Sarah started her nursing practice she found it difficult to carry out her duties. At first, Saudi patients did not want her to treat them because she lacked the knowledge and skills required in nursing. However, she said

this attitude did not annoy her or affect her. Sarah recognised that she needs to improve her skills and communication to work efficiently.

Even when she was not receiving encouragement, the more the patients refused her, the more she wanted to show how competent she was. As her nursing career continued, she came to convince the patients of her capabilities. Now, she says, 'most of the patients call me by name to assist them'. Sarah emphasised the importance of Saudi nurses:

> 'Saudi nurses are essential for the Saudi patients, because no matter what expatriates nurses show in their interest in patient's care, their language does not help, but Saudi nurses are definitely appropriate for understanding the situation of their patients.'

5.5.9 Lila

> 'As a Saudi, we need time to develop but not without courses and resources!'

Lila completed an Associate Degree at a health college. She has worked as a nurse for five years and she was interviewed at her work. She has worked in a female surgical and medical unit as well as in a Maternity and Children's Hospital.

Lila had wanted to be a nurse for a long time before she began studying. Her family disapproved of her ambition of becoming a nurse, but she managed to convince them to allow her to follow her dreams. She still hopes to improve her skills and continue studying to complete her degree.

Like other participants, Lila expressed her opinions and described what could be done to improve the nursing profession in Saudi Arabia. She was concerned with the shortage of nursing courses and the lack of resources. In her interview, she stated

that 'we need time to develop but not without courses and resources'. Lila also

mentioned the notion of mixing and its impact on Saudi female nurses. She chose to

be a nurse because she felt that nursing as a profession was suitable for a Saudi

female. However, she did not agree with the notion of mixing in nursing, but

recognised that it was related to nursing as a profession.

5.5.10 Khadijah

> 'When I practice nursing I feel like I am doing something for God
>
> (Almighty).'

Khadijah has a diploma in nursing and was in one of the first groups to

graduate from a HI. She later obtained a midwifery certificate. She worked as a nurse

for more than 10 years before leaving to work as a social worker after applying for a

position at the new Department of Social Work at her hospital. She said her job as a

social worker was better than nursing because of the nature of nursing work and its

impact on the social life of the female Saudi nurse.

Khadijah highlighted the condition of Saudi nurses and stressed that Saudi

nurses required more attention from the administration. She also pointed out some of

the obstacles facing Saudi nurses. She said, 'the lack of proper training affects the

ability of Saudi nurses.' Khadijah also commented on the lack of proper organisation

and noted that 'there is no development due to the absence of training and

encouragement'.

5.5.11 Faten

> 'We as Saudi nurses can practice nursing care and carry out the
>
> task more logically and better than expatriates nurses.'

Faten graduated from a HI and has worked as a nurse for five years. She was interviewed in her workplace. She said she loved nursing because it has a very big reward from Allah (God). According to Faten, 'only Saudi nurses can take care of their people'. In addition, she said 'we as Saudi nurses can practice nursing care and carry out the task more logically and better than expatriates nurses'.

After Faten graduated, she started nursing with inadequate skills and information. At the HI, Faten said the study was in Arabic: the only thing taught in English was medical terminology. Faten found it difficult to develop her nursing skills. She said the difficulties she faced were mostly related to a lack of proper nursing education.

Her lack of English language skills prevented her from communicating with those who knew nursing. In the interview, Faten pointed out the same problems the other participants experienced in regard to the lack of Saudi nursing instructors and lack of proficient nursing management. At the beginning of her practice as a new nurse, she could not find anyone to supervise her and demonstrate to her how to carry out her role of a nurse. In addition, she said, 'the expatriate nurses did not teach Saudi nurses for fear of them taking their positions'.

Faten's family did not influence her interest in becoming a nurse, but when she married she found it hard to continue in her profession. Faten left nursing because of issues related to being married and because she encountered poor management policy. These issues made her look at alternative work that would suit her commitments at home and as a wife. She became an educator of diabetic patients and found her lifestyle became more flexible and she became happier because she was no longer under pressure from the nursing administration.

Faten's story exposed the difference between being a nurse and working outside nursing, she said:

'When I was working as a nurse in the ward I started my work at 7 am
and finished at 5 pm. But now I am very happy with my work. I come
to work at 8 am and go home at 1 pm.'

5.5.12 Rufaida

'I proudly say I am a nurse and … I tried to explain to others how
good and pleasant such a noble profession is.'

Rufaida graduated from a health college and has been working as a nurse for
6 years. She worked in a PHCC before transferring to a hospital. At the time of
interview, Rufaida was working in the ICU; she found nursing in the ICU
completely different from what she had been doing at the PHCC. Rufaida liked
nursing and found it interesting. She said she did not have problems being a nurse
because she was not married.

Rufaida reported experiencing conflict with nursing management. She said
that unless nursing management improved, then she would probably leave nursing.
In her view, the nursing administration does not care for the nurses, which has
caused her to consider following other nurses who have left nursing. 'It is better than
struggling with them [management],' she said. However, her preference is to
continue working as a nurse.

5.5.13 Aisha

'We need to be like other who considered the nursing task as
valuable … nursing as a profession should not attack against the
religion because it is part of the religion.'

Aisha is a female Saudi who graduated from a health college and has five
years' experience working as a nurse. At the time of the interview, she was working

in an ICU. Her decision to be a nurse was encouraged by her father, despite objections from other relatives. She said, 'my father was the only one who encouraged me to be a nurse.'

As a female Saudi, she faced problems due to her profession. Again, one of these involved marriage. She revealed she was due to get married after two months and expected that she would find the working conditions difficult in her new situation. She supported the objections of other nurses in relation to this.

5.5.14 Norah

'My experience in nursing gave me courage and confidence in myself.'

Norah studied for a diploma from a HI and has been working as a nurse for 15 years. She lives in Dammam and was told about this research by female friends. Norah was interested in participating. She contacted the female interviewer and agreed to meet her in Riyadh, where she was interviewed at the female interviewer's home.

Norah has experience in different clinical areas including in PHCCs and hospitals. She spent three years working in the PHCC before she moved to the hospital. She has worked in female medical, surgical and Orthopaedic units. Before training in the field, Norah never expected to be a nurse. However, when she heard about the HI, she thought about nursing as her future profession. She decided to study nursing with her female friends, who encouraged her.

As Norah began practicing as a nurse, she felt that the work of the nurse was humane and good. However, she also understood that Saudi society viewed it as a strange profession to be pursuing. At the beginning of her practice, Norah was very shy and frightened. She said, 'I did not believe that I would have the capability to

work in nursing'. She explained this in relation to her status as a female Saudi. Like others female nurses, Norah had to face the public and the patients; she pointed out that she was not able to adapt to the situation. This was the reason for her continued shyness.Norah added that she was closed in inside a house from which she could not get out due to traditions and customs. She said, 'A daughter cannot have to go out alone from the house and she cannot speak with a stranger'.

During the interview, Norah was optimistic about her profession. She said, 'I will serve my profession sincerely and I will try to develop myself continuously'. Norah revealed that her experience in nursing gave her courage and confidence in herself and that this experience helped her in knowing how to meet the public and how to familiarise herself with the new environment. At the end of the interview, Norah wanted to send a message to Saudi girls and tell them to study nursing without fear or hesitation. She said 'nursing' is a humanitarian profession and our country is in need of the Saudi female nurse because she can understand the language, customs and traditions of Saudi Arabia and she can convey a psychological and moral service to the patients.

5.5.15 Amlak

> 'When I was working in the hospital, my relatives convinced my
>
> father to stop me from working there.'

Amlak lives in Riyadh and she has been working as a nurse since graduating with a diploma from a HI 23 years ago. She was interviewed in her workplace. Amlak had spent time working in a hospital as a nurse. However, due to family circumstances she was transferred to the PHCC. She recalled: 'when I was working in the hospital my relatives convinced my father to stop me from working there'. Amlak's father objected to her working in this hospital and helped her transfer to a

PHCC. She stressed that, 'my father was convinced that work at the PHCC had less mixing than hospitals.' Amlak is now working at the PHCC as a nurse in charge of vaccinations. She said that after graduation, most female nurses liked to work in the PHCC, as work there is easier, with work hours suited to home duties. Also, female Saudi nurses can avoid mixing with men at these centres.

Amlak chose to study nursing because the study at the HI looked easy and the prospects for work afterwards were good. She said, 'I knew that nursing was humanitarian work, but if I was not encouraged by my colleagues, I would not be in this profession.' Upon graduation, Amlak was not ready for nursing. However, she took responsibility for herself and tried to learn by observing the expatriate nurses. 'The difficulties helped me to depend on myself', she said. She said most of her subjects at the HI were in Arabic, but some subjects were taught in English. She explained that the information on nursing and its skills provided was basic and inadequate and that the study was too simple. However, as soon as she started nursing, her skills gradually developed. She said she improved her skills through working in the hospital with colleagues. She said, 'working at the PHCC gave me the ability and the courage to understand the health and psychological problems of society'.

Like Sami, Amlak is thinking of retirement, she said:

> 'Twenty-three years in-service is not easy for a Saudi woman. I got tired, and I am not like before, and I need to rest. I have to compensate my children for what they lost. My children are in need of me, they grew and their problems grew with them.'

5.5.16 Huda

> 'Nursing is a noble humanitarian work. Our religion encourages
> work in nursing and one will be rewarded if he works with good
> intention. There was humanitarian motivation that attracted me
> towards nursing.'

Huda is a female Saudi nurse who has completed the nursing programme in both a HI and a health college. She lives and works in Riyadh and is now working in the hospital as a Head Nurse. She has been a nurse for 10 years. Huda was interviewed by the female interviewer in the hospital at which she works. She chose to study nursing because she wanted to help others. She said that since her childhood she loved to help her relatives and colleagues. As a nurse her ambition to help others grew, and this helped her overcome the difficulties she faced from her family upon joining nursing. Huda decided to become a nurse not because she was thinking of the financial aspects, but because she liked the profession. She said, 'Nursing is a humanitarian work that brings good and happiness.' She also explained that nursing was the profession of female companions (May Allah Be Pleased with Them) of the Prophet of Islam (PBUH) and she wished to become like them.

Like other participants, Huda expressed what female Saudis feel and what they require in their profession. She stressed that the Saudi female nurse must be given the chance to work and to improve her skills. She pointed out many obstacles facing the Saudi woman when she works as a nurse. She explained that when the female Saudi nurse is married, she will not be able to work.

5.5.17 Reem

> 'I am proud of my work as a nurse and I will do my best to
>
> develop.'

Reem's qualifications include an Associate Degree from a health college. Like Huda, she lives and works in Riyadh. She has been a nurse for 12 years. She is working as a Head Nurse in a hospital. She was interviewed in her workplace. Originally, Reem was thinking of studying at the Medical University. She wanted to be a doctor but eventually chose to be a nurse. She said 'this is the will of Allah' and 'I want and you want but God decided what he wants'. Nursing for Reem is noble work. She chose to be a nurse because the task of nursing is related to her duty as a Muslim.

She revealed the main problems that she encountered when she started her nursing practice and exposed her experiences of being a nurse. She said the English language is one of the problems facing Saudi nurses. For her, the desire to be a nurse encouraged her to defeat all difficulties that she faced. Her desire to work had a great role in developing her skills, she said. She decided to be a nurse even though she was aware of the attitude of the society towards female nurses. 'I knew that the society does not accept Saudi nurses but I was ready in all aspects.' She was also aware of difficulties in dealing with patients and adapting to work hours. She said, 'I held all these things in my mind before deciding to be in this profession. I expected to deal with all these kinds of things and I prepared myself psychologically for nursing work despite the criticism, difficulties, risks and horrible scenes in the practice'. Reem added, 'I am proud of my work as a nurse and I will do my best to develop. '

Reem's experiences revealed many issues with nursing education, nursing practice and the organisational structure of the nursing profession. She was also

concerned with some aspects in relation to society and the reason Saudi nurses leave nursing. She said that people believe that nursing work in hospitals is against Islamic traditions and laws. In her interview, she highlighted that, 'Most Saudi girls do not like nursing because of the notion of mixing with the other gender'. In her opinion, mixing occurs frequently.

5.6 Islamic Cultural and Religious Considerations

In interviewing the above candidates, cultural safety was achieved, and Islamic guidelines were adhered to, by satisfying the gender requirements of males being interviewed by a male and females only being interviewed by females, with an experienced female interviewer being employed to interview all female participants.

In reference to the guidelines provided in the National Statement on Ethical Conduct in Human Research (2007), all nurses who participated in this research were provided with a consent form. The consent forms used were written in Arabic, and were attached to the explanatory statement, which detailed the nature and purpose of the research and the method required for data collection. The consent form was signed by each participant before the interviews started. Participation in this research was voluntary and the participants had the right to withdraw. The inquiry was unlikely to cause any further embarrassment, pain, distress or emotional or spiritual discomfort to participants. Much distress had already been experienced by many of the participants, such as that caused by wanting to stay in nursing but being pressured out by cultural conflicts or because of poor working conditions in which not enough support was provided by nursing authorities. I did not want to add to the participants' worries and tried to provide an environment for the interview in which they would be relaxed and able to speak freely, without any thought of judgment.

No nurses said anything to indicate they thought that their interview transcripts would be used for any purpose other than stated, and they all appeared to trust that the information gathered would be treated confidentially.

All the audiotape cassettes were labelled with a code number rather than by name. The data collected was stored in a locked filing cabinet in my home while I was in Saudi Arabia, and the university based computer had password protection so that only I and my supervisors could have access to this data. The data will be destroyed five years after the completion of the research as per Monash University regulations.

5.7 Establishing Trustworthiness

'Qualitative research criteria must be used to fit with the

philosophical assumptions, purposes, and goals of the qualitative

paradigm' (Leininger, 1994, p. 97).

It is not enough to have an ethical approach to the conduct of the research. My research also needs to be conducted in such a way that if reproduced (or used as a model), the details of my research would be sufficiently clear so that they could be followed by any other researcher.

According to Leininger (1994, p. 96), qualitative researchers should not rely on the use of quantitative criteria such as validity, reliability and generalisability to explain or justify their findings. Credibility, transferability, dependability, meaning-in-context and confirmability are five criteria often used for the effective evaluation of qualitative research. These criteria were developed by Leininger (1994) and Guba and Lincoln (1989) and have been supported by other researchers such as Koch (1994) and Wolcott (1994). These criteria are recommended as qualitative criteria to

be used in supporting and validating qualitative research (Leininger, 1994). It is these criteria that I will now explain in relation to my research

5.7.1 Credibility

Credibility was established by careful consideration of ethical, religious and cultural issues, as well as by logically establishing a research method. According to Leininger (1994), the participants are the primary gatekeepers and the researcher is the secondary gatekeeper for information and to prove findings. The researcher has the important task of grasping the participant or informant's meaning in the fullest possible sense. In this way, 'credibility refers to the truth as known, experienced, or deeply felt by the people being studied (emic or local) and interpreted from the findings with co-participant evidence as the "real world" or the truth in reality' (Leininger, 1994, p. 105).

Within the cultural norm, Saudi nurses were able to use their own words to explain their view of being a Saudi nurse. During the initial part of the interviews, we informally discussed whatever issues the nurses raised and I (or the female interviewer that I trained to interview the female participants) gained some understanding of how the nurses felt, what their needs were and what their experience of nursing was.

Interviews were based around prepared questions that stemmed from my primary research aims. Cultural sensitivity was maintained throughout the interviews. The interviews were conducted in Arabic, the native language of the subjects—the language in which they could best express themselves.

As outlined in Section 5.4.4, I performed all translations, checking, rechecking and back translating to Arabic to ensure accuracy, before further editing was undertaken. This editing sought to avoid changing the original meaning of the

nurses' responses. In some cases, I showed the translated version of the interview to the interviewee. However, a copy of the interview transcript was provided only to those who requested it. In these cases, these participants were happy that the meaning of what they said was maintained in the translation.

5.7.2 Transferability

Transferability refers to how the findings are generalised from samples to the whole group (Holloway & Wheeler, 1996), which in this case is Saudi nurses as a whole. After much thought, it was decided to survey the more significant characteristics of the Saudi nurses; these are, gender, whether or not they are still nursing, educational background and city of origin. In accordance with this, we surveyed enough nurses so that the sample displayed a wide selection of these characteristics. The implication is that, since our data are drawn from nurses representing a variety of different circumstances, we can be fairly certain that the similarities in their viewpoints are reflective of the larger body of nurses, regardless of their gender, current employment status, educational background or city of origin.

However, qualitative phenomenological research is not satisfied with generalisations. A full understanding and knowledge of particular phenomena is important and this usually involves further research. The transferability criterion also focuses on general similarities of findings under similar environmental conditions, contexts or circumstances (Leininger, 1994). This means the transferability criterion is about other researchers doing further research along the same lines. By replicating their research in a comparable situation, researchers can further examine the data to see if further research supports the findings of this research.

5.7.3 Dependability

Dependability is related to, and usually follows, credibility (Robson, 1993). The dependability of my research is also indicated by the careful examination of drafts of my thesis and planned methodology by supervisors, friends and an editor. This careful examination became a checklist of advice and helped to guarantee the dependability of the research. Descriptive methods are used in the analysis, based on the interview data. These provide enough data to achieve accurate results, which can then be interpreted objectively (Dewadry, 2005).

5.7.4 Meaning-in-Context

The participants and I share particular cultural understandings in common with all Saudi Arabians. The meaning of the data in this research needs to be understood in relation to the different geographical and environmental contexts of the participants. This criterion encourages the researcher to consider the data in the wider context. Therefore, I have taken the time to note certain characteristics of the participants such as where they lived, their family situation, social and economic status and whether they were married or single. According to Leininger (1994, p. 106):

> 'The significance of interpretations and understandings of actions, symbols, events, communication, and other human activities, as they take on meanings for informants within their lived context or the totality of their lived experiences, supports this criterion.'

5.7.5 Confirmability

Confirmability occurs with credibility, transferability and dependability (Koch, 1994, p. 978). It is:

'Affirmation that the findings, conclusions, and recommendations

are supported by, or grounded in, the data and that there is

concordance between the research's interpretations and the actual

evidence' (Hoskins & Mariano, 2004, p. 68).

To this end, I have taken measures to ensure every step I have taken has been

logically made and carefully recorded.

In this research, the nature of the knowledge obtained is that it is about the

reality of being a Saudi nurse. The validity of this knowledge is confirmed partly

from my understanding of the lived experience of Saudi nurses. According to Porter

(1996, p. 116), 'our knowledge of social reality equates with our understanding of

the meanings and motives which guide the social actions and interactions of

individuals'.

This will allow other researchers to duplicate my research and compare their

findings to mine. Further, others will be able to examine the merits of my research

by following the logical steps I have taken and examining them for themselves to see

whether 'the conclusions and interpretations arise directly from them' (Daymon &

Holloway, 2002, p. 270).

5.8 Conclusion

The research design, based on hermeneutic phenomenology, involves

interviews and careful transcription, interpretation and examination of the

interviews. The interviews have opened the door to the lived experiences of the 17

Saudi nurses who have participated in this research.

The advantage of using a phenomenological framework for this research is

that the researcher is part of the research and better able to give a sense to the whole

experience as revealed by the participants. Phenomenology helps the researcher to understand the uniqueness of a phenomenon that represents the essence of being a Saudi nurse. It offers the possibility of understanding and exposing the Saudi nurses' lived experiences in the context in which they live and work. As the researcher, I was able to use my background to assist in understanding the meaning of the lived experiences of being a Saudi nurse from different perspectives and arrive at concepts and generalisations as a result of things seen, experienced or believed to be real by the participants.

The nurses interviewed were proud, caring nurses (or ex-nurses). They willingly participated in the research and their contributions have been well-documented. The findings are written up in the next chapter.

I have found the research framework to be an appropriate methodological approach for both analysis and interpretation of the texts in this research inquiry. By following van Manen's methodological structure jointly with the phenomenological method, Saudi nurses' lived experiences and perceptions of being nurses are revealed and the meanings of those experiences are captured.

Chapter 6: Findings

6.1 Introduction

The experience of the participants in this research provides an insight into the life of Saudi nurses and indicates the controlling influences upon these nurses. These influences do not support Saudi nurses in their profession. The Saudi nurses' experience of their profession is that they face a tyranny of neglect. Through a Husserlian phenomenological analysis of the interviews, various themes have been identified. The organisation of the data has allowed major themes to emerge. The data are grouped under the major themes with associated sub-themes. These themes and sub-themes are classified into two essences.

The themes relating to contradictions in the value of caring and conflict with social structure are grouped together as 'Sociocultural Factors'. These themes relate to external pressures that Saudi nurses face. Themes relating to the paradox of organisational commitment and lack of empowerment are grouped together under the heading 'Organisational Paradoxes' (see Figure 6.1). These themes relate to problems within the internal structure of the nursing profession.

Sociocultural Factors	Organisational Paradoxes

• **Contradictions in the Value of Caring**
   • Misunderstanding Nursing Work
   • Attitude of General Population towards Nursing
   • Nursing Established From a Non Saudi Perspective
   • Saudi Patients lack the Benefits of Having a Saudi Nurse
 	
• **Conflict with Social Structure**
   • Conflict Between Working Conditions and Islamic Social Values
   • Confusion From an Islamic Perspective Concerning the Issue of Mixing
	• **Paradox of Organizational Commitment**
	   • Contradiction in Practice
	   • Lack of Appropriate Management
	   • Lack of Support
	   • Saudi Nurses are Leaving
	• **Paradox of Empowerment**
	   • Contradiction in Leadership
	   • Unjust Financial and Other Rewards
	• **Paradox of Communication**
	   • Paradox of Change
	• **Paradox of Education**
	   • Lack of Educational Opportunities in the Nursing Profession
	   • Inadequacies of the Education System
	   • Inadequacies of Private Institutions
	   • Unqualified Supervisors
	   • Lack of Preparedness after Graduation

Figure 6.1. Classification of the main categories including themes and sub-themes indicated by the data.

Findings in these two categories explore the nurses' lives and work, reveal the context of their lives and consider the cultural background, social interactions and organisational factors that contribute to the low quality and status of nursing. Findings from this research reveal a sociocultural paradigm that segregates being a nurse and being a Muslim; inadequate support from family and society was frequently cited by the participants as a key obstruction in regard to the wellbeing and effectiveness of nurses. Participants also asserted that the commitment of nursing organisations towards nursing education, practice and management does not reflect the cultural values and principles of Islam.

Due to an inaccurate perception of nurses by Saudi society, most participants indicated that they do not or did not find satisfaction in nursing. Yet almost all participants, including those who have left the practice, claimed they should be experiencing nursing as a rewarding career because nursing is characterised by the caring ideals of Islam.

As the results will show, the reality of the context in which Saudi nurses live and practice their profession is not a positive one. This context is characterised by contradictions and neglect and requires urgent attention and change. This statement is consistent with the definition of nursing as 'a dynamic dialectic of contradictions' (Hodges, 1997, p. 350) and is further supported by Waterman, Webb and Williams (1995) who argue that:

> 'As nurses … we live and cope with many tensions or
> contradictions that are dynamic and evolving … some of these
> tensions need to be addressed and settled, if only partly, for major
> changes in practice to occur' (p. 55).

6.2 Sociocultural Factors

One key theme that continually emerged during the data analysis concerns the major issue of confusion. Saudi nurses are confused by the contradiction between their caring roles as nurses and the negative view that society has of them. They are confused by the fact that Muslim teaching indicates nursing is a noble and worthwhile profession, whereas Saudis believe nursing is not a worthy profession.

Such sociocultural factors affect the Saudi nurse's social status. They refer to the desire of Saudis to choose nursing as a career path and the choices of current nurses in continuing their profession. The inadequate understanding of the nature of

nursing care and its relation to Islam has created a gap between being a nurse and being a Muslim. The following themes emerging under this category are divided into two groups: 'Contradictions in the Value of Caring', and 'Conflict with Social Structure'.

6.2.1 Contradictions in the Value of Caring

Due in part to the fact that Saudi Arabia relies greatly on overseas nurses, Saudi society primarily associates nursing with expatriate nurses, rather than seeing the profession as suited to Islamic values. Participants indicated that Saudi society misunderstands the concept of nursing. This leads to an ignorance of the concept of caring from an Islamic perspective. Islam is about caring and nursing is about caring, so they should be compatible. However, participants reveal that the development of nursing in Saudi Arabia has been held back by neglect and derision. Saudi society as a whole does not respect nursing, despite the fact that Muslim women were nurses during the time of the prophets of Islam. These issues are further compounded by the fact that expatriates nurses can work with either gender. As a consequence, Saudi society finds it difficult to move past gender-related nursing issues (for example, mixing) to be able to comprehend nursing in human terms as a necessary caring profession. Contained within this theme are the issues of:

1. Misunderstanding nursing work,

2. Attitude of general population towards nursing,

3. Nursing has been established from a non-Saudi perspective, and

4. Saudi patients lack the benefits of having a Saudi nurse.

6.2.1.1 Misunderstanding Nursing Work

The value of nursing care is often poorly understood in Saudi Arabia. The role of nurses, what is involved in nursing and the place of nursing in an Islamic

culture, are misunderstood. Saudis do not speak about nursing, the media does not promote nursing and there are few suitably qualified Saudi nurses to enlighten others about nursing.

The participants interviewed make statements such as the following to indicate their initial lack of understanding and the lack of understanding of society:

'Some of my family objected to me being a nurse. They still object because of their wrong idea that nursing is mixing genders. They said, "How do you work in this kind of job?" They accepted the importance of nursing only after I explained that there is no mingling at all, and those who we are working with were female and serving only female patients' (Aisha).

'Especially in this city, the people did not really understand the role of the nurse. In their minds, to be a nurse is to be mixing with the other gender' (Faten).

'When my friends asked me about my job … I tried to explain to them how good and pleasant such a noble profession is. They do not know how I feel when I give care to others. I always feel happy when I provide nursing services because being a nurse is part of how I practice my religion. It is always important when the patient says they will pray for me' (Rufaida).

'I did not have any background in nursing. The objective was to find a job … By the time I passed the first year, I felt that nursing was strange and that it wasn't compatible with our temperament, customs and traditions. I was ignorant of what nursing really is … I

felt that I was just a servant and that I couldn't be a nurse because I didn't know enough about nursing. If I don't know the job, how can I do it? I felt no desire to continue studying and tried to quit. I actually did leave for three weeks, but my father and some colleagues encouraged me to return. I think because I was young— just an adolescent—that I refused to do some practical studies that involved things like a lot of blood or critical injuries' (Ahmad).

'I had no information or background about nursing. I didn't even know the function of the nurse … The majority of the society in which we live looks to nursing as an unfavourable job. Even after graduation no one dares say that I am a nurse; we are ashamed of this. Their idea is that the function of the nurse is limited to the bandages, injections, cleaning and turning the patient from side to side' (Khalid).

'I did not plan to be a nurse, but when I graduated from high school my friends told me that they wanted to study at a health college … I had already decided to enter the University of Medicine but it was far from the city where I lived. My father did not allow me to travel … I did not have any idea about nursing before studying nursing. I didn't even understand the role of the nurse. When I started the course, everything was new for me and gradually I liked the profession … Society does not know what nursing is about; they only know that nursing is the work of foreigners. Most people are surprised when someone hears about a girl working in nursing because they believe the working

conditions are not in agreement with the culture of the country'

(Zainab).

'I don't think that society is aware of the real role of the Saudi

nurse. Although nursing is important for our country and despite

the fact that our society is in need of it, it is still viewed as an

inferior job according to many people. When [female] nurses work

in a hospital, people believe that their work is against Islamic

traditions and laws' (Reem).

Further, Sarah said,

'Most people do not really understand the work of nurses; they

only think that nursing is not suitable for a Saudi woman.'

This is supported by Reem, who said:

'My niece had no idea about the work of the nurse and her role in

serving society. She was telling me it is like the work of a

housemaid, but when I explained to her the nature of my work as a

nurse and the noble humanitarian role I performed in helping

patients, she joined nursing and became a nurse. Many of my

relatives work in nursing. I am proud of my work as a nurse and I

will do my best to develop my abilities.'

There is further confirmation from others:

'Some of the people in our society are not happy when they learn

that I am a nurse. They even ask, "Why did you choose such a

career?' (Aisha).

> 'Most of my friends ask me about how I deal with patients and
>
> how I give injections. Some of my friends and relatives wonder
>
> how I work in a mixed gender situation and deal with men such as
>
> the physician or male patients. There are many questions from
>
> people about the role of nurses, because most nurses are foreign
>
> female nurses' (Norah).

What other profession has students enrolling for study without knowing what the profession is really about? Unfortunately our society knows almost nothing about the role played by the nurse. Waleed describes Saudi society as only looking at nurses from a narrow-minded viewpoint:

> 'Society points to male nurses as being interested only in working
>
> with foreign women. It is really only patients who know the role of
>
> the nurse.'

A lack of accurate information about what is involved in nursing is likely responsible for such misconceptions. Although it is expected that people who have been treated in health centres and hospitals appreciate the reality of nursing, it seems that even these people remain silent when it comes to improving the image of nurses in Saudi culture; some even remain critical of nurses.

In Saudi Arabia, nursing, as a caring profession, is full of contradictions. On the one hand, our society promotes caring, especially from an Islamic viewpoint. However, nursing is not promoted as a caring profession. Such aspects of nursing are misunderstood or hidden. In addressing this problem, Sarah stressed the importance of empathy. 'When my friends understand the nature of nursing duties and tasks, they appreciate not only my work but nursing work in general.' Amlak emphasised

the significance of education, suggesting that, 'Saudi nurses must educate society about their roles'. In addition, she concludes that:

> 'We, as nurses can change the attitude of society to us through good nursing and relating and participation in developing nursing. Many female patients ask about me by name and that is because I cooperate with them and I help them in answering their requirements. '

Waleed revealed:

> 'Many native Saudis don't know what nurse means and some do not know the difference between nurse and physician. Many clients call me Doctor and only a few know the difference between doctor and nurse.'

The misunderstanding of the role of nurses permeates Saudi society. However, when people learn about the true nature of nursing they often become supportive, as in Reem's case, below:

> 'Most of my friends did not encourage me and they told me that there is mixing with men in the work of the nurse, but when they understood … they encouraged me. Most of my friends asked me about my ability to work with patients in a mixed environment. They are surprised how I work as a nurse. Some of my relatives used to criticise the role of the nurse; they told me it is like the role of a housemaid in the house. They did not think about … the nurse in terms of looking after the patient. This role involves more than what a physician does because nurses do everything that a patient

needs. I think when one understands the real role of the nurse they appreciate her profession and encourage her.'

There are many areas of misunderstanding in Saudi culture. These misunderstandings range from what nursing students think nursing is really about, to the benefits of Saudi nursing. Some of the misunderstandings are related to the customs of a society which contradicts the work of the nurse. However, the lack of formal education significantly impacts on the status of Saudi nurses in society. According to Sami, 'the low level [of] educational qualifications leads to poor performances of the nurses and to society looking down on nurses'.

This statement reveals the need for change in the education of Saudi nurses, especially as Saudi nurses have limited skills and knowledge compared to their Western counterparts. This is evidenced by Sarah, who wondered why some of the patients did not want to be treated by a Saudi nurse. She said:

> 'When I asked a patient why she didn't want a Saudi nurse, she answered that it was because Saudi nurses are still learning and most of them are lacking skills.'

Saudi nurses should be well educated to positively reflect their duty and loyalty. Lila highlighted that:

> 'Most patients do not understand whether the nurse is a trainee or an employee; they just look at us from one perspective—that Saudi nurses do not know their work and expatriate nurses are better.'

The statements above suggest that qualified Saudi nurses are best placed to change society's perspective on nursing and allow others to understand the nature of their work.

6.2.1.2 Attitude of General Population towards Nursing

Not only do people who deal with nursing misunderstand the profession, but this misunderstanding also extends to the general population. The attitude of Saudi people towards nursing is a major sub-theme that has emerged from the participants' interviews. This sub-theme underlines the contradiction of the value of nursing. Norah said:

> 'Patients in the hospital understand nursing work and appreciate Saudi nurses while those who have never been in a hospital do not even know what nursing is all about. They do not respect nurses because they say bad things about nurses.'

Rufaida added:

> 'The people around us did not support nurses; even my family agreed that society would not accept nurses.'

Faten said:

> 'The situation here is unacceptable. Some of my friends asked me why I did not become a teacher.'

Aisha added:

> 'The situation is not the same as before. There are some people now who prefer Saudi female nurses to care for their wives … Saudi society needs to be aware of the role of Saudi nurses. People should know our importance so they can change their opinion towards nurses.'

Norah commented that, even though her family is now supportive, she still faces almost overwhelming difficulties as a nurse:

> 'Our society won't accept the idea of having men and women working together, whatever the reasons are, but my family understands the situation and they did not object to my work as a nurse. But, I really faced difficulties from outside my home and family … Family and friends do not understand the work of the nurse due to a lack of nursing information. However, my family did not object to me becoming a nurse.'

Zainab said:

> 'Objection came more from outside the family, from relatives of my father and my mother, for example. They do not want me to be a nurse. The most important reasons for their opposition involve the mixing with men.'

Sarah supported the above comments. She said:

> 'My friends often asked me how I could be a nurse. They don't like the concept of nursing because it's related to the concept of mixing.'

Sami revealed that,

> 'Our society views nursing as the work of foreign women.'

Ahmad shared the advice of his colleague on handling these difficulties:

> 'When someone asked him [my friend] about his job, he used to answer only that he was a government employee. People felt

contempt for him and undervalued his role when he [said he] was a

nurse.'

Sarah revealed a similar view and links it to the low status of Saudi nurses:

'Some of my friends are nurses and they don't want to tell others in

the community that they are nurses.'

Educational background, in most cases, is linked to the performance of

nurses and their position in society. Ahmad described the reaction of people when

they knew that someone was a nurse. He said:

'They will say to you, "What do you want to do with nursing,

nursing is work for female foreigners and also it is a mixing job"?

Working as a nurse looks bad due to a lack of knowledge of

nursing and its role in serving society.'

Most of the participants stated that only those who do not really know the

facts about nursing will argue against nursing as a suitable profession. Ahmad added:

'To work as a nurse in this country means you work in co-

existence with female nurses … [these difficulties are why I left]

… I am not working in nursing now but I am proud that I am a

nurse.'

Waleed also encountered pressure due to the perception of nursing being a

profession that necessitated mixing with foreign women. He said:

'My wife does not like me to work with foreign female nurses

because of jealousy and she does not like night shift work for me.

> Can you imagine that you leave your wife at night and go to
>
> work?'

Waleed's experience is important. Some nurses find it difficult to marry because of their work in nursing, as a woman may not accept marrying a male nurse who mixed with females at their workplace. Further, a female nurse may have a similar problem due to her work in this field. However, Waleed explained that, 'now, it is important to work so as to marry, and men like to marry a female nurse because of her salary'.

Each nurse who participated in this research has coped with many different issues and all of these elements make working as a Saudi nurse a challenging experience. Expatriate nurses have an advantage over Saudi nurse because expatriate nurses speak the language of the hospital and understand doctors' orders. Conversely, Saudi nurses can speak the language of their patients and understand the cultural traditions of the society and are better able to provide culturally sensitive care. This is one reason that Saudi nurses do not accept society's attitude towards male and female nurses. The participants reveal that although there have been some improvements, society's attitude towards nursing is still underdeveloped. Unfortunately, even though the attitude of the Saudi population is changing, this does not mean that nursing will become an accepted profession. Waleed stated:

> 'The attitude of society affects both male and female Saudi nurses
>
> … Sometimes there are pressures from society or people close to
>
> Saudi nurses to leave the profession because it does not agree with
>
> the nature of Saudi society. For example, mixing, shift work and
>
> the nature of the work of the nurse are not acceptable.'

Zainab said:

'I liked being a nurse. Nursing is a great humanitarian work. When I started my nursing practice, I was the only Saudi in the hospital where I worked. Since I was not well equipped with nursing knowledge and skills, I found it difficult to cope with the practice. One of the most important issues was the lack of a common language to communicate with other nurses. Another issue is that Saudi patients did not trust new Saudi nurses and most of them were not willing to be treated by a Saudi nurse. As I worked in the hospital, people looked at me differently; most Saudi men did not appreciate my job as a nurse. They often said 'God forgive you' to me because I was a nurse. This is because of the nature of the nursing working conditions, which are seen as not suitable for Saudi females.'

Khalid concurred:

'Now the view of society is changing and people are starting to accept the Saudi nurse because some nurses have proved themselves … Most nurses are ashamed to say they are a nurse.'

Ali also agreed:

'Even my mother, when she knew that I worked with women (mixing), didn't want me to practice this work and she was afraid when I worked at night.'

These statements are further supported by Ahmad:

'Nursing is considered to be a handicap, especially in the opinion of family and relatives. You feel some bitter or sharp words about

the job from them. I was mostly affected by it and even the work of

the nurse along with blood, pus, dirt and cleaning and other work

which is difficult for the new graduate. This affected me and many

students at the beginning. Some students even left because of these

things. But praise to almighty Allah, my desire to practice the job

has bypassed all difficulties.'

6.2.1.3 Nursing Established From a Non-Saudi Perspective

Nursing in Saudi Arabia in modern times is dominated by nurses and nursing

processes from different countries. Nursing models are Western and the language of

nursing is English. There are many problems with Saudi nursing because it has been

established without consideration for the context of practice. One such problem is

that nursing does not cater for or consider the unique cultural background and

cultural needs of Saudi nurses. According to Ali:

'Nursing work does not cope with the Saudi nurse's requirements

due to their traditions and family habits. The married nurse finds it

difficult to work certain shifts, and the nursing department does not

take into account their culture. Because of this, the nurse chooses

to work outside the field of nursing … according to customs and

traditions, I remember that I had to go home to attend to an

important matter, but when I asked the nursing department to allow

me to go home they refused. This is because the manager of

nursing was a foreigner and he did not care about the convenience

of the Saudi nurse.'

Awareness of the patients' cultural backgrounds is an important part of

nursing. For this reason, foreign nurses simply cannot do the job that is needed in

Saudi Arabia. This is a significant motivation for Saudisation. The participants in this research indicated that:

> 'There are many foreign nurses who are unable to understand patients' customs, traditions and religious beliefs … a foreign nurse will never be sufficient. Any nurse, whether male or female, that doesn't become familiar with the customs, traditions and religion of the country, will not be able to offer the necessary nursing care … The Saudi patient (male or female) requires special treatment that foreigners find difficult to understand' (Khalid).

Faten summarises the situation by stating:

> 'We as Saudi nurses can take care of our people better than expatriate nurses do.'

She talks about the bond that can exist between a Saudi nurse and their patient when she says, 'the patients usually pray for us'.

All the participants agreed. For example Norah commented on the 'lack of understanding between the foreign nurse and the Saudi patient'. In fact, some patients do not accept foreign nurses and most of them complain about the manners of the foreign female nurses. This is, of course, attributable to difference in traditions and customs. Sami clarified that, 'also, there are no programmes and education courses for teaching the foreign nurse the Saudi traditions and customs'. Amlak notes that foreign nurses are 'lacking the confidence to share the patient's worries and problems because of the culture and the language'. Other participants views on this matter are shown by the following comments:

'The expatriate nurses did not come here to work to make improvements to the nursing profession and they did not come here for the sake of the patients—but they came for money' (Imtinan).

'Expatriate nurses lack conscientiousness when dealing with Saudi patients; they are not tender and kind when providing nursing care. Many expatriate nurses deal harshly with patients. Some of them work as nurses just for money but not for the sake of providing good nursing care to Saudi patients' (Khadijah).

Similarly, other female participants did not deny the preferred role of expatriate nurses, but said:

'Many foreign female nurses … don't know Arabic. Most patients need someone who understands them and tries to help them psychologically. The Saudi patients need someone who teaches them and explains to them the nature of the service provided. Most foreign nurses do not have sufficient ability to deal with the Saudi patients' (Huda).

'When an expatriate nurse attempted to give the medication to a patient, she didn't introduce the procedure she was about to give. When the patient asked, "What is this medication for?" she said, "It was written by the doctor" ... Not all foreign nurses who come to work in Saudi have the same certificates and experience. Most of them are not well equipped with good nursing experiences— they do not really know how to deal with Saudi patients' (Sarah).

'Most expatriate nurses ignore the patients simply because they do

not understand them. The nature of illness must be known before

we deal with the patient. If you do not understand what the patient

is complaining about, then you are ignoring the patient's rights'

(Imtinan).

Waleed expressed that:

'One of the most important requirements of the nurse is his

understanding of the patient. I don't think that foreign nurses

understand the Saudi patient and that is because of different

customs and traditions.'

As a consequence of the culture and language, it is true that Saudi nurses can

understand their patients' needs better than non-Saudi nurses. The perception of

Saudi nurses is that the role of a nurse is not only to attend to a patient's physical

condition, but also to observe the psychological, moral, social and cultural aspects of

the patient. The participants believe that non-Saudi nurses lack this capability.

Regarding this, one of the female participants stated:

'Foreign nurses do not have enough experience to deal with the

Saudi patient. In most cases, their manner is not suitable for the

Saudi patient … Some patients … need someone to help them and

listen to them. Sharing worries with the patient is a kind of

emotional help. Some patients lack good manners and most foreign

nurses do not have this either. In some cases, the manner of dealing

is the healing' (Amlak).

Participants maintain that the Saudi male and female nurses offer compassionate care to their hospitalised compatriots, while the foreigners provide service for the sake of money only. Imtinan said:

> 'When I worked with expatriate nurses, I did not feel that they really cared as we Saudi nurses do. When a patient asked them something and they could not understand it, they would just leave. Even when the patient was angry, they would leave them unaccompanied. They are not like us. They do not try to make patients calm and comfortable in order to find out their problems and find solutions. Most patients became angry when the foreign nurses did not understand them.'

Imtinan's statement is supported by others. Norah, for example, said:

> 'Foreign nurses do not care about how their patients respond to treatment or for how their patients feel. Saudi nurses know the culture and know how to deal with Saudi people.'

Further, Zainab revealed:

> 'Most foreign nurses do not support patients psychologically; they only do the job they were asked to do, but they do this without really caring for the patient. Due to the lack of Arabic language skills, most foreign nurses find it difficult dealing with patients. It is fair to say that they have a lack of compassion for Saudi patients.'

Development of Saudi nursing must consider these cultural and religious factors. If this does not happen, Saudi nurses will not be happy in their work and

they will continue to leave. Continuing reliance on expatriate nurses will not improve the nursing profession, but will continue impacting on the care delivered to Saudi patients.

6.2.1.4 Saudi Patients Lack the Benefits of Having a Saudi Nurse

All the participants agreed that Saudi nurses are the best ones to serve Saudi society, but many of the nurses interviewed shared the opinion that Saudi nurses lack nursing skills:

> 'From my experience, some patients did not really like Saudi nurses because of their lack of skills. And it is true, many of us do lack skills. We had difficulties since we graduated with low knowledge and skills. Saudi nurses could not handle responsibility and most of us lack the proper skills and appropriate knowledge needed for the nursing profession … We try to do our job well, but some patients prefer expatriate nurses. They prefer expatriate nurses because of their lack of confidence in Saudi nurses and in their ability to work … Patients preferred non-Saudi because they felt that they are better and more knowledgeable and for these reasons the government brought them to care for us' (Khadijah).

> 'The Saudi patient thinks that the expatriate nurse is more skilful than the Saudi nurse. For example, I have had work for a long time in wards with patients. Sometimes when I attend to a patient the patient refuses, saying, 'I need the expatriate nurse.' But we don't get upset, we continue trying to attend to them so as to build a bridge of confidence among us' (Aisha).

'Saudi patients were not confident in the ability of Saudi nurses because of their low qualifications in comparison to expatriate nurses. The patients were not satisfied with the performance of Saudi nurses due to our inability to speak English. During the first week of my employment, one of the patients asked me to explain what the expatriate nurse said. I told her I did not know. The patient said that if I did not know, how could I work with them?' (Faten).

This lack of nursing skills is a problem because Saudi Arabia needs capable Saudi nurses. Expatriate nurses simply cannot do the same job, as shown by the following comments:

'The patients want foreign nurses because they think the foreigner has had more experience and knows more than Saudi nurses. Thank God the situation is improving. Now many of the patients are happy to be treated by Saudi nurses. Since they have realised the importance of Saudi nurses, they often support the Saudi-trained nurse' (Zainab).

'Most of the time I try to explain to the patients the importance of Saudi nurses and the Saudi nurse's role in providing nursing care to Saudi patients is considerable' (Khadijah).

'I had to convince the patients to accept my caring; most of them did not want to be treated by a Saudi nurse. Some of them refused and others would not trust Saudi nurses to treat them or offer them nursing care. For example, when I gave them medication, they

would ask me if I was sure about it. They never asked this of

foreign nurses … To overcome this, I tried to convince the patient

by telling them that I was a trained nurse and I can do better than

foreign nurses' (Sarah).

'Native nurses can play a major role in nursing. They are the only

ones who can understand the patients. The nature of their

psychosocial situation can't be understood by expatriate nurses …

All patients need help to understand the expatriate nurses'

(Khadijah).

'Patients often require help and because expatriate nurses cannot

understand their problems they will not help them and some of the

expatriates are tough with their patients. One patient told me to tell

the expatriate nurse whom I worked with to be polite. It was hard

for me to tell them, but I told her that the patient was not happy

with what she did to her' (Rufaida).

Saudi nurses understand their patients better and can be more sensitive to

their patient's needs. Patients come to know this, but the general public does not.

Following is a story from Aisha that illustrates how, when confronted with a need for

a nurse, patients and their families came to realise nursing's value.

'One time my father lost consciousness in front of me and I

immediately aided him until he recovered. I felt I was of great

value, since he was the only one who encouraged me to be a nurse'

(Aisha).

Imtinan said:

'I wish all nurses were qualified Saudis because highly skilled nurses are best for the patients. Patients in most cases feel happy when they find nurses understand them … Many Saudi patients ask for help. They always seek the Saudi nurses' assistance. We are happy and they thank us and praise God (Almighty) because the Saudi nurses were able to take responsibility for their needs. One patient told me that, "the daughters of the country (a term used by the patients to refer to a female Saudi nurse) are capable of understanding our situation." Most patients say that Saudi nurses have tenderness, which is not found in expatriate nurses. With this tenderness they can understand the patients and give them what they want and this is a form of treatment.'

Sarah said:

'I usually greeted the patients when I entered their room, asking each one what she wanted or needed. We as Saudi nurses are different than expatriate nurses; before we start giving any service or treatment we mention the name of God, then try to explain exactly what we are going to do. Most expatriate nurses can't explain the procedures to their patients.'

Sarah and Lila further clarify the importance of Saudi nurses and mention the difficulties that Saudi patients face:

'Of course Saudi nurses are essential for caring for Saudi patients; because no matter how much interest expatriate nurses show in their patient's care, their language does not help. Saudi nurses are

definitely more appropriate for understanding the situation of their

patients' (Sarah).

'Saudi nurses by their nature can understand the customs and

traditions of their patients. When a Saudi nurse knows the English

language he or she will not improve in their work, but they can

help the patient understand the expatriate nurse and help translate

the suffering of the patient. Many Saudi patients were crying for

help. The expatriate nurses could not understand their suffering …

In my experience, Saudi patients preferred a Saudi nurse because

she or he understood their viewpoint and was able to give help and

support. When I was new, there was one patient who refused to

allow me to give them an injection but they allowed the expatriate

nurse to do so. They said that "the Saudi nurse had a soft heart and

could not handle the needle and give the injection". As she said

that I understood that she did not trust me' (Lila).

These quotations reveal that Saudi nurses feel their role in nursing to be

invaluable because, unlike foreign nurses, they can provide culturally safe care. The

principal reason that expatriate nurses cannot satisfy this requirement is that they

lack a common language and culture with their patients. Moreover, they do not have,

or do not take, the time to build their knowledge of the Saudi culture. Therefore,

Saudi nurses are the only nurses that can provide this care.

Saudi nurses would perhaps be happier if all nurses were Arabic-speaking

culturally aware Saudis, but they are not. We cannot do without foreign nurses.

According to Ahmad, the problem is that 'if foreigners leave, we will have nobody to

assume their duties. And if they leave, the science of nursing will leave with them'.

The participants clearly expressed that caring has an important effect on their patients. They also said that expatriate nurses find it difficult to attend to all of a Saudi patient's needs. However, patients continue to doubt the skills of Saudi nurses. As Waleed said, 'some patients do not trust Saudi nurses'.

Despite this last statement, it seems that Saudi nurses are usually preferred by Saudi patients because they understand the cultural background and the needs of the patients, and because they work towards gaining their trust. In the words of Imtinan:

> 'Today is not the same as yesterday; before there were no Saudis working in nursing, but now there are. Some Saudi nurses tried their best to improve their skills because they like their profession. Before, Saudi patients liked to be cared for by expatriate nurses, but now they have seen the differences, they have become aware of the genuinely important function of Saudi nurses. Now most patients prefer us. I often hear the patients saying that they wish all the nurses were Saudi.'

Reem concurred:

> 'In the beginning, I faced difficulties … Being a Saudi, I was not accepted by the patients at the beginning because they are not accustomed to Saudi female nurses. My interest in participation and presenting a good image in front of the patients gave me their trust and made them accept me willingly.'

Ahmad's experience was similar:

'At the beginning we were not accepted by the patients, because of inadequate nursing knowledge. But when we worked as a nurse the patients depended on us.'

Others added:

'I learned a lot from my experience and I am still learning. The most important thing was that I learned how to achieve the trust of the patient. As a Saudi nurse, we lacked the required encouragement from others in the profession. I tried my best to accept what others said about the nursing task, but I kept improving my manner towards others and especially towards patients. Many things that I learned were part of our culture and religion' (Sarah).

'Saudi patients preferred those who were able to treat them adequately. The most important thing for the patient is the attitude of the nurse, and some nurses get upset when the patients refuse them. Whether Saudi or expatriate, a nurse must deal with the patient in a good manner which the patient will appreciate' (Lila).

There is no doubt that Saudi nurses can offer what the foreign nurse cannot. However, the benefits of this extra care depend on the nurse having the appropriate level of nursing knowledge and skills. Amlak was one of the female participants who acknowledged that:

'Most patients call me by name, and ask about me when I am absent. When one patient complains, I deal carefully with her and I consider all patients as my mothers and I respect them all. Most of

the old women are uneducated, and if you don't understand well

how to deal with them their problems will increase … I tried my

best to provide a good environment to solve many of the problems

which I had to deal with in my nursing, or at least to relieve my

patients [fears]'.

Reem added:

'The Saudi nurse is able to offer a nursing role that serves society

and enhances the progress of society's health. It is easier for the

nurse to help the patients when she understands their problems'

(Reem).

Sarah also stressed the importance of Saudi nurses. She said:

'Saudi nurses are better informed about the nature of society; they

speak the language and understand the condition of the patient. But

our society has the idea that foreigners are better than Saudis.'

Norah shared her story about one Saudi patient to show the vital role of the

Saudi nurse. She said:

'I remember one patient who was admitted to the hospital in the

evening and during her second day there I met her. She was

frightened, but when I greeted her she said, "Thanks be to God.

You are an Arab?" "Yes aunt, I am Saudi," I said. The expression

on her face began to change and she cried. She said, "Where have

you been? Since I entered this hospital nobody has understood me,

and nobody tells me what is going on. They are just taking blood

and I don't know what the reason is." I explained everything to this

female patient and calmed her down and she was alright. She

prayed for me, wishing me success, then said, "Oh my daughter,

don't go and leave me with these people … they don't care for

me"'.

The above statements indicate how Saudi nurses are appropriately managing

Saudi patients. Knowing the culture of the patients is critical for informed nursing

care. It is essential that nurses communicate effectively and avoid cultural

misunderstandings that may stem from nursing care from nurses who cannot speak

the language of the patients. However, language is not the only barrier. Saudi nurses

are also better able to share a cultural understanding with their patients. The

importance of fully understanding the patient is explained by Waleed below:

'Some patients need special treatment. I remember when I worked

as a nurse at the Male Medical Unit, most of the patients showed

that they were unhappy with the work of the foreign nurse. If

nurses do not understand the patient, or the reverse happens, we

can say that service is incomplete. Understanding the situation of

the patient plays an important role in diagnosis and nursing care'

(Waleed).

Participants pointed out that patients always need care and education and that

nurses must share the concerns and worries of their patients. They explain that being

a good nurse helps them win the trust of their patients and that most patients are

looking for somebody they can share their worries with.

The ability of a Saudi nurse to understand Saudi customs and traditions helps

them act in response to patients' needs. However, nurses also need someone to

understand them and respond to their needs. The conflict that exists between their

social structure and obligations, means that Saudi nurses, both male and female, are finding it difficult to continue in their profession.

6.2.2 Conflict with Social Structure

Saudi nurses are confronted by many social and cultural difficulties while struggling to cope with their nursing duties. Often, if not always, they are pulled between their cultural obligations as Saudi's and their duties as nurses. They have to change and adopt new cultural norms into their daily nursing practice and social lifestyles. Most of the participants have revealed that they feel confusion from an Islamic perspective. This confusion primarily involves their working conditions.

The conflict between the role of nurses and Islamic teaching has not yet been resolved. Working conditions are causing continuing problems. An undesirable working environment, coupled with long working hours, hinders the satisfaction of Saudi nurses as well as those who are thinking of becoming nurses. It is especially difficult for a Saudi female; her duties as a nurse are seen as conflicting with her cultural obligations within Saudi society.

The following themes indicate the perceived confusion under this category:

- Conflict between working conditions and Islamic social values

- Confusion from an Islamic perspective, concerning the issue of mixing

6.2.2.1 Conflict between Working Conditions and Islamic Social Values

This initial sub-theme is attributable to the conflict with the social structure. It is mainly due to insufficient consideration of the Saudi culture. The most obvious problems relate to inappropriate working conditions for Saudi female nurses. Amlak, based on her 23 years in nursing, asked,

> 'Do the people in charge forget that the female Saudi nurse has a
>
> family and a home? '

Imtinan added:

> 'I feel that salary is not as important as happiness. If I am not
> comfortable in my job, I will not enjoy what I earn. I work nine
> hour shifts and when I get home I find myself tired and wanting to
> go to sleep. Sometimes I don't find time to sit with my child. Other
> nurses said they don't have time to sit with their husband and
> children.'

Nursing organisations do not concern themselves with issues involving Saudi
nurses such as the social conditions of female nurses. The added pressure on female
nurses affects their ability to continue in nursing. These views were shared by the
other participants:

> 'Non-observance of the social conditions of the female nurse, long
> work hours, mixing, husband and home responsibility are some of
> the most important factors' (Amlak).

> 'Most families do not agree with their daughters working into the
> night or staying long hours in the hospital. They do not accept such
> things. Most female nurses are willing to work in the Health Centre
> because of issues relating to mixing. In the Health Centre, there is
> no mixing with men. Therefore, most female nurses are willing to
> work there' (Zainab).

Sarah supported the above statements, saying that:

> 'The presence of a husband and children require that the wife
> should be there with them … The husband has the right and the
> house has the right and if Saudi female nurses have children they

have their rights too … When I told my family that I would join a
nursing programme they did not disagree. They even respected my
decision to be a nurse, but they worried about the working
conditions. They said, "How do you work in a place where there is
mingling with men, in addition to the long working hours?"'

Lila expressed a similar view. She said:

'The objection of my family was about the working conditions: the
length of working hours, inflexibility of working shifts and
unstable working environment (the mixing issue). But because of
my insistent desire to be a nurse, I was able to convince my
family.'

In the above comments, Lila is not complaining about the working
conditions, but is pointing out that her family is concerned about these issues. Many
families are like this. They do not understand the sacrifices nurses sometimes need to
make, and believe that nurses, especially female nurses, should not make these
sacrifices.

These factors have been mentioned by most of the participants. Amlak
provided further details:

'My work hours at hospital are from 8 to 5 in the evening, so what
is left of the day hours? Do the people in charge forget that the
female Saudi nurse has a family and a home? Some nurses play the
role of mother at home, and some of them have children and the
responsibilities at home require availability of the mother. Most
nurses left work due to their social circumstances. Most married

nurses have housemaids, but housemaids cannot replace a mother
… When I leave work, still there is work. Home needs cleaning,
children need someone to help them in their study and my husband
needs care. There is always endless work … Retirement after 23
years in service is not easy for a Saudi woman. I got tired, and I am
not like before, and I need to rest. I have to compensate my
children for what they lost. My children are in need of me, they
grew and their problems grew with them … according to my
experience in nursing and my work in this field, the Saudi woman
is able, but their status must be improved and problems in nursing
must be solved. For example, long work hours are not right,
especially when the female nurse is married. [However] If the girl
finds support and encouragement, she will continue her work in
nursing.'

Imtinan stated:

'Yes, long working hours have had a negative impact on married
life and especially on the children. Imagine a mother spending
most of her time outside of her house. What will happen? I had a
daughter who is suffering because of my work. She did not want
me to go to work because it is long. She said, 'Mum, I don't want
you to give me gifts and buy me anything. I just want you to stay
home with me. She became psychologically ill. As I lived far from
the hospital, I had to leave for work early in the morning, about 6
am, while she was sleeping. My work started at 7. And because my
work ended at 4pm, I almost always arrived home late. When I

returned from work, it wasn't long before she had to go to sleep.

The nursing administration didn't care whether it was a long shift

for the female nurse or not, or whether I had children or not. It is

not their concern because most of the nursing managers are

expatriates.'

Reem and Imtinan pointed out that:

'Saudi nurses face problems with shifts and the nursing work does

not fit the conditions of the family and home. Work hours are long

and there is no consideration for family circumstances and

marriage is one of the obstacles for being a Saudi female nurse'

(Reem).

'Still our community rejects the work of females as nurses; the

problem is that the community does not know the real and true role

of the nurse. I knew many Saudi girls willing to be a nurse, but

because the job of nursing involved mixing … they could not enter

the nursing profession. This matter affects female Saudi girls in

choosing nursing as a career' (Imtinan).

The Saudi nurse also has to content with a range of social problems As

Amlak states, 'there are many social problems which I cannot mention.' These social

problems stem from the working conditions of Saudi female nurses and their effect

on the Saudi nurses' participation in the community and in their home life. One of

the social problems mentioned by Lila is the tensions that can arise between a

husband and wife. Lila explained:

'Most of my colleagues had problems managing both home and work. Saudi female nurses faced difficulties with their husbands because of this instability between home and work … One of my female friends is a nurse and she was divorced because of the instability between home and work. If my husband returned from work and did not find me, it will create serious problems, as he told me once that there would [be] no problem with me working [as long as] it doesn't conflict with what a spouse is supposed to be. When he comes home to the house he needs me to be there with him.'

Imtinan added to this:

'Yes, the job of the nurse can cause a Saudi female nurse to delay getting married, and it can possibly be a reason for divorce after marriage. Most couples do not like the working conditions of nurses, because of the long working hours; this alone can cause many problems, which lead to an end by divorce. However, most female Saudi nurses are not married.'

Marital problems and divorce are devastating for everyone, especially the children. Divorce is not an acceptable part of Saudi culture and affects the parties for the rest of their lives. Other participants explained why female Saudi nurses do not want to work in the hospitals:

'After graduation, most nurses like to work in the health centre, as work there is easier, with work hours suitable for home duties, and also you can avoid mixing with men at these centres. This of

course gives the Saudi nurse some peace of mind. Many families allow their daughter to work in nursing, but they object to mixing with men at work' (Amlak).

Further, Sarah believed that:

'It is not easy for Saudi female nurses to work 8 to 9 hours at the hospital. Most female nurses find it difficult to manage this, especially when a nurse is married.'

Lila concurred:

'Even though we as Saudi female nurses did not work on public holidays (Thursday and Friday), the working hours were long compared to other professions such as teaching. In addition, the nurse's job is hard and interferes with social requirements. For example, the length of working hours often conflicts with the requirements of the Saudi female nurses at home and this is seen as a barrier.'

She then expanded on this idea:

'How can I take care of my home if I am working from 3pm to 11pm? These long hours create difficulty for many female nurses and lead to problems for couples. Many female nurses are having continuing problems with their husbands because of this issue and the proportion of divorce among the Saudi female nurses is high.'

Balancing home life and nursing is a very difficult task. In Western countries, there is greater flexibility for nurses, such as the ability to work part-time. Further,

Western nurses have the option of living alone or with family. In Saudi Arabia, the social structure is different. Saudi female nurses, as well as male nurses, are living with their families—sometimes with their parents, but mostly with their husbands (or wives) and their children. Saudi society also has different expectations of family life. For example, it is the woman's role to care for the house and they need to be home during the day to care for their children. Traditionally, this has been a major role for Saudi women. Nursing is one of the few occupations in which female Saudis are employed professionally in the workforce. Elsewhere, professional employment is the male's domain. The inflexibility of the Saudi social structure, means that it is difficult to accommodate the requirements of the nursing profession (long working hours and the female nurse's inability to stay at home with the husband and children) and reduce conflict between the Saudi female nurse's working and home lives.

For some, nursing has been an escape from the domain of home. However, this escape is into a world of contradictory demands (see Section 6.2.1). Many nurses leave nursing because of these demands.

6.2.2.2 Confusion from an Islamic Perspective Concerning the Issue of Mixing

Saudi nurses are affected by cultural traditions concerning the opposite sex. Men are protective of their women (wives, sisters, mothers, daughters) and mixing with the opposite sex is considered socially inappropriate because of the belief that interaction could compromise their chastity and modesty. Any compromising of modesty affects a woman's reputation as well as her standing in society. Islamic beliefs affect many aspects of nursing in Saudi Arabia and the relationship between men and women in the workforce is seen as very significant.

Due to the 'mixing' that can occur in the nursing workplace, Saudi society considers nursing to be incompatible with the requirements of Islamic law. It is generally believed that nursing is not suitable for a Saudi female. Reem says:

'Mixing has negative effects and psychological consequences. Therefore our religion orders us to wear a veil (*hijab*) and not to mix with men, to avoid seduction and to protect women and men from falling into sin … Yes, in nursing there is mixing with men.'

According to Norah, 'in nursing work, there is mixing, and the female nurse speaks and deals with men', although in Imtinan's case, 'mixing occurs only during the doctor's rounds'. Regardless, the mixing issues is the result of a contradiction in Saudi society. First, according to society's understanding of Islamic teaching, there are guidelines and rules to be followed. In contrast, there is the actual situation that nurses find themselves in and the demands of being a nurse, which is a necessary caring profession. The following interview extracts highlight this:

'Society now understands the nursing job, but the attitude towards mixing is based on religious teachings which must be followed, because the female nurses are responsible for their behaviour and Allah will account her for it' (Amlak).

'Free mixing in general is something but with limitations it is something else. If it's free mixing without limitation it is not allowed. But who is our example/model? Our God and his messenger (may peace be upon him). Nursing during the time of our prophet was limited only to women, was that mixing? So the

mixing in nursing is restricted by Islamic rules. Allah alone knows'
(Ahmad).

'There is confusion. If we look at the shopping mall and other
areas we will find there is mixing with other genders and the
situation is normal. But when it comes to the working condition of
the female nurse the situation is not considered normal. Why is
mixing always a concern with nursing duties? Of course there is no
answer to this question'! (Sarah).

Amlak revealed that she had been working at the 'men's section' at the
hospital. Her relatives convinced her father to stop her from working there and, at
her father's request, she transferred, together with her sister, to work at a health
centre. Amlak explained that her 'father was convinced that work at the health
centres had less mixing than hospitals'. However, some nurses said that mixing was
not such a problem:

'I don't care for mixing. This does not affect the nurse who
understands the situation and who has confidence in her
personality. Go to Mecca in the holy mosque and you will find
mixing. The female nurse is responsible towards her work and [for]
complying with the Islamic principles and moral values is
necessary' (Norah).

'I don't see any prohibited mixing in nursing work … We connect
these things with customs and traditions. The customs and
traditions supersede the reputation of the religion. If we return back
to the origins, we will be aware there was no prohibited mixing in

nursing work. Nursing was legitimated by the messenger (may

peace be upon him) when all nurses were female. We didn't hear

about male nurses at that time. The messenger (may peace be upon

him) didn't forbid nursing' (Ahmad).

Despite this, the female nurses interviewed preferred working in the PHCCs

because there, they could work in female only work environments, tending female

patients. Amlak said:

'My family had no objection at the beginning for my work as a

nurse, but some of my relatives did not accept my work, and the

reason is not the nature of the work itself, but the reason is that

they don't accept "mixing with men at the workplace". My father

refused my work at the hospital because of mixing.'

Imtinan received support for her choice of profession, saying:

'I did not have a problem with being a nurse and my family

encouraged me. I heard that there are some people who did not

accept the occupation of nurse for the female Saudi, but as long as

my family and I were convinced about this profession it didn't

matter if the people accepted that or not.'

Amlak raised the point that:

'Female nurses are responsible for their behaviour and Allah will

hold them to account for it … The problem is not in mixing, but it

is in the girl herself. No man can do anything or harm the

reputation of an honest woman against her will. The girl is

accountable for her deeds to Allah, and she must be clear and frank

during her work and she must comply with the principles and teachings of Islam. It is difficult for the female nurse to leave her veil and her religion and reputation because of her job. Many female nurses were forced to leave the job due to mixing.'

Sarah stated:

'Even in a mixing situation, if we work towards accomplishing our duty in order to offer a service for our community, then we must be respected and accepted.'

This is the main problem with mixing—nurses leave their job because of it. The reason female nurses leave their job when it comes to mixing is that the society they live in believes mixing goes against Islam. Just the act of practicing as a nurse is enough for a person in this profession to be seen in a poor light. Considering that Saudisation is actually targeting nursing as one of the first professions to receive government help to increase the number of Saudi employees, this view of nursing as an unsuitable profession for Muslims represents a serious contradiction between the beliefs and the requirements of Saudi society. Indeed, despite the recognised need for Saudisation in nursing, the required nurses are not being attracted to, or retained by the profession. According to Waleed:

'The problem is that the number of Saudi female nurses is still insufficient due to obstacles and difficulties facing women in this field, which are related to mixing with males and the attitude of the society.'

Saudi nurses are constantly being pushed into situations in which they need to try to explain or justify their involvement in mixing. Waleed said mixing is one of

the main problems causing female nurses to leave their profession. The necessity of mixing in the workplace causes confusion and makes the life of a nurse much more difficult. One of the biggest problems facing nursing in Saudi Arabia is the poor retention rate of Saudi nurses. Sami further illuminates the stress placed on Saudi nurses because of mixing with a personal story:

> 'There is also the problem of working with women. Even nurses do not feel psychologically well, and it is not convenient for him to work with a lady. Society is very tough about this and you may lose respect. Also a complaint may be raised against you and there is no law that protects the nurse. Nurses have no references or special entities which can protect him. When I was working at the hospital one of the religious people advised me to leave the work of nursing because of mixing with women. He asked me to make my salary lawful (*halal*) and to work away from this place. He said working with female nurses is not permitted by Islam.

6.3 Organisational Paradoxes

There are many paradoxes in nursing in Saudi Arabia. At the government level, the promotion of Saudisation in nursing despite the prevailing view of society that the profession is not suitable for Muslims is one such paradox. There are also more endemic paradoxes within nursing, such as in the teaching of nursing (for example, in the language of instruction), the supervision of nurses and the rights of nurses. These can be grouped together under the headings of 'Paradox of Organisational Commitment and Lack of Empowerment'.

The stories of the participants depict conflicting images of nursing organisations. These conflicts cause difficulties in a profession that is determined to maintain legitimacy in increasingly uncertain times. For example, there are contradictions in nursing management, which is meant to support nurses and represent their interests, but which, in reality, does not. Further, there is a significant gap between nurses' training and the requirements of practice, due in large part to a power imbalance between Saudi and non-Saudi nurses. Saudi nurses are restricted from communicating effectively in the workplace and seldom receive training or support from the expatriate nurses, perpetuating the image of the inadequately prepared Saudi nurse. Therefore, this power imbalance impacts the Saudi nurses' access to education, key resources, information and effective practical communications.

6.3 Organizational Paradoxes

6.3.1 Paradox of Organisational Commitment

Nursing as a profession aims to meet the holistic needs of both Saudi nurses and patients. However, this has been proving difficult due to a number of factors that are obstructing the development of the nursing profession in Saudi Arabia. The identified themes under this sub-category are as follows:

- Contradiction in practice;

- Lack of suitable management;

- Lack of support; and

- Poor retention rates.

6.3.1.1 Contradiction in Practice

Nurses who have left their profession have reported frustration. Inadequate education and training was found to be prevalent and most of the participants claim they were taught insufficient nursing knowledge and that they possess inadequate nursing skills due to a lack of professional development. One female participant asserted that at no time during her working life as a nurse was she offered in-service education. Amlak said:

'I worked for 16 years in nursing and I have not taken any course, and many colleagues have the same experience. Courses can increase knowledge and improve performance. My knowledge of nursing needs continuous support. There are new things which we must know and we have to improve. Nurses need continuous education. To join courses, you must know some powerful people to help you and to make mediation for you.'

Rufaida added:

'Our relations with expatriate nurses are not really good, because they feel that we (the Saudi nurses) are taking their place. There is a sort of jealousy between us and some of them treat us as enemies.'

Others said:

'I faced many difficulties as one of the first group to graduate from the HI. I was the only Saudi female nurse in the hospital; all the other nurses at that time were expatriates. There was no support when I started working as a nurse and expatriate nurses could not help me because I could not participate with them and I lacked the

knowledge of most of the nursing procedures. I had to follow the

expat nurses to understand their work and see what they do in order

to learn and adapt … The expatriate nurses have more

opportunities than Saudi nurses. They can be selected to be a head

nurse or a nursing director and they can attend lectures and

participate in programmes and courses—but Saudi nurses have

only one right, their salary' (Khadijah).

'When a new expatriate nurse begins her job, her fellow friends

take care of her and explain everything to her. For us as Saudi

nurses, there is no one to teach us. If we need to know something,

we always ask the doctors. The expatriates don't really care about

us. I often learn by imitation, observing and looking at what they

are doing then trying to do it' (Aisha).

Of course, as in any profession, there should be support and ongoing training

for nurses. Nursing management should provide this and ensure the best possible

environment to nurture nurses and meet their needs so that they can perform their

duties well. However, there are clear discrepancies between what nursing

management should be doing and what it actually does. For example, Waleed stated:

'There is some kind of mismatch in nursing work. There are

problems between nursing and administration and between the

nursing administration and hospital administration at the hospital.

There is something missing between the boss and the subordinates.

In most cases, the boss is a foreigner and he does not observe

conditions and circumstances related to Saudi nurses. There are

some people who practice spying on Saudi nurses and there are

some people who report inaccurately about Saudi nurses.'

Ali, no longer working as a nurse, said he felt injustice when he was working. In his view, 'the nursing department is just a name for nothing. This department does not play any role in developing the Saudi nurse'. Ahmad shared a similar view, saying, 'there were many problems between managers and employees'. Ahmad revealed a story that ought to be of concern to most Saudi nurses. When he first graduated from a HI he was employed at a psychiatric hospital. He recalled:

'They directed me to a psychological health hospital; I worked

there for a short period of time where I faced many difficulties in

nursing policy and management … When I moved to work in the

psychiatric health hospital … they didn't qualify and assist me with

an education course, but only told me to go and work there. This

happened with some nurses who had been out of nursing for a long

time.'

Some Saudi nurses who left their profession did so because of intolerable working conditions, yet they were later forced to return to their practice because they could not obtain any other work that they were qualified for. This paradox in management reveals a lack of support and encouragement—a lack of duty of care. While some Saudi nurses have been allowed by nursing management to leave the profession, others have not been allowed, and others have been forced to return to their practice. This creates problems for nurses due to unequal treatment. Most nurses return to their practice lacking the required skills, such as in the case of Ahmad:

'I was placed in a position where I felt lacking most nursing skills

which I didn't practice for a long time, and I lacked information

about the psychological patient who really requires special care.

Sometimes I was alone with the patients when the place was closed

and I was fearful. This was the nursing policy; to frustrate nurses.

They don't want nurses to be successful and so they fight the

nurses. This had a big impact on me and I even thought about

leaving the job. Just imagine. A nurse faces psychological

pressures and works in a psychological field. What will be the

result? This pressure led me to move and work in an administration

job in the specialised hospital and now I am working at the medical

records centre. Since that time, I have not practiced nursing**.'**

It is clear from Ahmad's interview that he left nursing because of a

contradiction in practice—the nursing body that was meant to represent and support

him instead 'hid the specialised courses from us', and their policy was 'to frustrate

nurses' (Ahmad).

Ahmad's concern was also shared by other participants. For instance, Imtinan

stressed that:

'When training courses for nurses are going to be held in the

hospital or in a different place, the administration does not tell us.

The nursing administration always nominates expatriate nurses to

attend these courses. Instead of choosing us to attend, we are the

last ones to know. The priority is always for expatriate nurses to

go, but not Saudis … I felt that as a female Saudi, I am not

important. I think it's better to nominate a Saudi nurses to attend

the training courses; yes, we are the ones who are going to remain

in this country. Most expatriate nurses come with no experience—

they improve their skills in nursing and then they go. Those who

worked in the MOH hospital for a long time finished their contract

and applied to other hospitals for a better salary.'

Zainab said:

'When I started working, I felt I was a stranger. In the beginning, I

did not find support from the expatriate nurses because I was not

good with English. They were not interested in teaching me or

allowing me to work. They only allowed me to do low-level tasks

such as checking vital signs, bringing the patient from the X-ray

theatre, transporting the patient with other nurses or changing the

linen. It is the Saudi nurse's responsibility to learn and understand

the work.'

Clearly, there is conflict and stress among nurses. Some focus on a belief that

the Saudi nurse should simply work harder to prove themselves. Some blame expats

for not being supportive and others blame administration. Lila expressed concern

about the lack of policy and revealed the difficulties she and other Saudi nurses

encountered. She said:

'The nursing task requires continuing educational courses. The few

courses offered were often far from the hospital where I worked

and this necessitated me travelling to attend those courses. This

just caused problems for me because I could not travel alone

because of religious reasons. While I am married and have kids it

is difficult to leave the house**.'**

Ahmad reinforced this common theme, saying:

'As a Saudi you will not be considered no matter how much you

work, achieved or are dedicated. Problems even sometimes come

from other Saudis in management. And the foreign nurse doesn't

want you to understand the work and then replace them. They

don't try to teach you, and the Saudis in some hospital are

prohibited from taking a management course.'

6.3.1.2 Lack of Appropriate Management

The participants clearly viewed the lack of appropriate management as

having a crucial effect on their working environment, interaction and performance.

Management plays an important role in any organisation. The primary aim of

management in nursing is to organise and control nursing resources and ensure an

efficient and effective nursing workforce. Unfortunately, this does not always

happen in Saudi Arabia. The participant's statements expressed the lack of integrity

and authority in nursing management:

'Yes, nursing management does not work to improve the Saudi

nurse's performance and makes us feel valueless in helping our

society. Nursing management does not work towards suiting our

requirement as female nurses. They don't even appreciate what we

are doing. In their eyes, all Saudis are the same whether we work

hard or whether we don't even come to work. We only need

support and motivation, so that we can improve our performance'
(Imtinan).

'We need nursing management to give us confidence and
motivation and to allow us to improve our situation' (Khadijah).

Ahmed pointed out that:

'Management does not want the success of the Saudi nurse because
management is not qualified. They don't want anyone to occupy
the management chair except them. There was fighting against the
nurse and no development! They used to hide the specialised
courses from us and not show it to us until the expiration date for
registration. This told me they didn't want anyone to develop their
skills.'

Khadijah said:

'When we asked the nursing administration if we could attend
courses, even at our expense, they said we needed to get someone
to replace us. We have been facing problems like this for a long
time and no one tries to improve the situation … The nursing
administration is making it hard for Saudi nurses to attend
courses.'

Ali expressed a similar view of the problems Saudi nurses faced from nursing
management. He said:

'I encountered some difficulties at the beginning and the nursing
administration did not take care of me … There is a lack of caring

for the Saudi nurse and no administration which is able to understand the nurse and encourage them to work. The administration must find solutions for the problems that stop the Saudi nurse from continuing in their work.'

Rufaida agreed:

'I had a problem with the nursing administration and I did not know what to do. When I complained to the hospital administration they told me to 'go to nursing administration, they will solve your problem.' How can I solve my problem with those I am complaining about? There are no proper channels and the general nursing administration never cares whether you have a problem or not.'

In Sarah's mind, there is 'no solution to many problems we faced'. Lila and Imtinan also pointed out that:

'Management did not find a solution to most of our problems because they did not care for us as Saudi female nurses. Since management is usually by expatriates, they do not really know exactly what the social life of a Saudi male or female nurse is like.'

She added:

'The nursing administration in the hospital did not encourage Saudi nurses and they continued supporting the expatriates because they feel they are better than Saudis. We lacked the moral encouragement and compliments from nursing management.'

The following statements give some indication of the attitude of nursing management towards nurses:

> 'There has been a group of excellent new Saudi nurses who are
>
> willing to work and improve their skills, but unfortunately the
>
> nursing administration transferred them to another place because
>
> they preferred foreign nurses' (Faten).

> 'There are 30 qualified Saudi nurses working at one hospital. Only
>
> 10 of them work in the field of nursing' (Sami).

The comments above indicate that Saudi nurses are not regarded as highly as expatriate nurses by the nursing administration. Further, nursing management does not support nurses in coping in their practice or in finding solutions to their nursing problems. This contradiction between the role of management and the reality—the lack of leadership and, as will be shown in Section 6.3.1.3, lack of exercise of the duty of care—seriously reduces the effectiveness of Saudi nurses in the workplace and their corresponding satisfaction with their profession.

6.3.1.3 Lack of Support

This paradox between the management ideal and reality in Saudi Arabia has a serious impact on the nursing profession. Despite the professed aim of management being to look after nurses and create a workforce everyone can be proud of, the effect of the current management style is that Saudi nurses are being driven out of the profession. According to the participants:

> 'If I had found support, I would still be a nurse … But still the role
>
> of the nurse is ignored … I wish to return but the situation is not

good while the Saudi nurse is suffering neglect and not being

taught or developed adequately' (Ahmad).

When we claim for anything we usually receive no response and the

administration neglects us completely. Nursing must be morally, psychologically and

financially supported (Reem). Waleed added:

> 'Because there's no one to listen to and help the Saudi nurses with
>
> their problems, this leads to male and female nurses leaving
>
> nursing ... The situation is poor and we pray to Allah to help us
>
> all.'

Khalid also stressed the importance of support:

> 'There is a lack of support and assistance from the nursing
>
> department. There should be a nursing body that cares about the
>
> concerns and feelings of nurses. The nursing department should
>
> ask about nurses' needs and reward the best nurses. They should
>
> help nurses who have problems instead of punishing them and they
>
> should try to motivate nurses.'

A couple of the participants emphasised that female Saudi nurses should

receive the same treatment as female Saudi teachers and outlined the differences

between the conditions of the two professions:

> 'We need to be treated at least the same as a female teacher. Saudi
>
> female teachers are more comfortable in their profession than
>
> female nurses' (Sarah).

'Women who work in teaching do not have the same problems as us because their working conditions are better. The working conditions of Saudi female teachers are suitable because they work less hours and have more public holidays. In addition to this, the teaching profession is accepted by our community' (Imtinan).

Teachers are encouraged to feel good about the work they do. Nurses are not encouraged enough. If the nursing profession is not accepted and continues to lack support in our society, Saudi nurses may feel just like Ali, who said:

'The [conflict between nursing and the] different traditions and customs affected me psychologically and I started to feel pressure and depression most of the time.'

Sarah also experienced initial unhappiness in her role:

'There was no one to support me at the beginning of my work. I was really stressed but I found myself happy when I met nurses who knew Arabic. Gradually I learned new things every day. I learned most of my skills by myself. But it took me a long time to learn the language used in the practice.'

Sarah added that,

'we [nurses] need support and recognition in order to improve our outcome'.

She was not alone in requesting support.

Imtinan stated:

'We wish to have training courses for nurses, so we can embrace

new ideas and take advantage of everything that is known about

nursing … But it doesn't happen … I faced many difficulties at the

beginning of my work as a nurse and I struggled to cope with these

problems. I became psychologically unwell. I could not participate

without the help of my friends (female Saudi nurses). They stood

next to me until I learned while most foreigners did not teach me

what I was required to know.'

Lila, Imtinan and Sarah pointed out that most new expatriate nurses arrive in
KSA without in-depth knowledge of nursing, but that they are mentored by other
expatriate nurses and, in this way, quickly develop their skills. In their words:

'Most foreign nurses gain experience when they work in Saudi

Arabia. Because of their large presence they have the ability to be

in charge of the nursing profession. Each expatriate nurse is caring

for the same nationality. For example, when new nurses are

employed they are guided by a colleague of the same nationality.

The new expatriate nurses usually benefited more than Saudi

nurses; they get more support and training from their peers of the

same nationality' (Lila).

'Our relationship with expatriates is not the same as if they are

Saudis' (Imtinan).

'A large number of foreign nurses learned their nursing skills from

working here and most of them were newly graduated: they only

gained their experience from working in Saudi Arabia. Some

foreign nurses said they came to work to gain experience and learn

new things, including how to use new medical equipment. "After

we learn what we need we will return to our country with the

knowledge", they say. Because of their contracts, some expatriate

nurses do not extend their stay due to the lack of freedom (Sarah).'

Certainly, Saudi nurses could benefit from being mentored in the same way

as expatriate nurses. However, as the participants explain, the expatriate nurses are

reluctant to share their knowledge or expertise with the Saudi nurses. The result is

that due to not receiving the support necessary to improve their practice, many

dissatisfied Saudi nurses leave the profession. This was Khalid's experience:

'The Saudi nurse has aspirations, but if they are not utilised and

developed they will vanish and the nurses will leave their

profession. This is what happened to me because I found no

support from my nursing department in the hospital.'

The other participants also told of their experiences in this regard:

'I know some of the married Saudi female nurses left nursing

because of the long working hours. These nurses were creative

learners and have high skills in nursing and are willing to practice

their profession, but could not work these long hours. Most Saudi

female nurses preferred to work in the health care centres because

of the length of the working hours in the hospital. This fact

hindered many Saudi female nurses from continuing in their

profession' (Sarah).

'Yes, nurses need our attention. Reduce the working hours. The

working hours of nurses are too long. The female Saudi nurse

spends most of her time in hospitals. This issue conflicts with the

role of the women in their homes. It causes female nurses to

neglect their homes, their husbands and their children' (Zainab).

It is very important that nursing issues such as this lack of support be addressed to improve the retention rates of Saudi nurses. The matter of retention rates is further addressed below.

6.3.1.4 Poor Retention Rates

At a time when the process of Saudisation is trying to increase the number of Saudi nurses, it is a significant problem that Saudis are leaving nursing. Nurses leave their job for many reasons, the most significant being the lack of support from both the nursing administration and society. The participants made the following comments:

'There are social circumstances that force nurses not to work …

Some nurses have transferred and work at the administration of the

hospital, and now they have more authority than the nurses in their

departments. This also leads nurses to be not interested in nursing'

(Waleed).

'Many Saudi nurses leave nursing because of long work hours in

nursing, in comparison to administrative work, and the problem is

that there is no differences between their salaries … it was easy to

transfer from nursing to other jobs with the same advantages and

incentives' (Ali).

'Yes, most Saudi nurses leave because of the difficulties they

encounter in their practice. Some nurses leave because they know

someone who helps them move to other, unrelated work. In my

situation, I left nursing because the administration needed me to do

another job. It was not my decision to leave nursing practice, but

the decision came from the Hospital Administration, because they

were in need of Saudi nurses who knew English to help with

translation, to help patients understand the foreigners and vice

versa. The hospital administration wanted me to have this position.

It seems to me I am a social worker' (Zainab).

Waleed, Ali and others point out that all the problems associated with nursing

contribute to nurses wanting to leave, and one main contributing factor is that 'other

jobs offer more incentives' (Ali). The problem of nurses leaving is such a problem

that nurses discussed penalties and guidelines about nurses leaving:

'A nurse should serve not less than ten years before leaving or

moving to another job' (Khalid).

'The transfer of nurses to work in other fields must be stopped and

nursing must have advantages over other jobs. It is important to

support nurses financially and to increase their salaries' (Ali).

Waleed told a story of his experience, explaining how other work can be

more attractive than nursing:

'As an emergency supervisor, I have one nurse who does not want

to work at night and he told me, "if my name is not put

permanently on the morning shift, I will transfer to another place. I

cannot come to work except in morning shifts because of personal

circumstances". I accepted his excuse. If in my place there was a

foreigner in charge of this nurse, he will not accept this situation.

And this is a situation with many nurses. Not respecting this

nurse's situation and refusing to help solve this problem, will

normally cause nurses to leave work. The availability of transfers

will cause most nurses working in nursing to transfer. A common

theme which is repeatedly uttered by nurses is, "I like to be like (so

and so). He works outside of nursing and he is satisfied. I want to

be released from this headache of putting on a suit, going to work

for the morning shift for one week and in the evening for another

week. I want to be like (so and so) who comes to work at 8.00 in

the morning and leaves at 2.00 in the afternoon every day, except

Thursday or Friday, and his salary is the same as mine. How lucky

I would be!"'

The organisational commitment of nursing management towards nurses is

clearly lacking. It is a paradox that management is supposed to assist nurses and

improve nursing as a profession, and yet it generally does not. Instead, management

usually neglects nurses, both in terms of professional development and in solving

their problems. By not supporting nurses, management is severely reducing the

ability of nurses to take control of their practice and positively influence nursing as a

profession. This lack of empowerment is discussed below.

6.3.2 Lack of Empowerment

A lack of empowerment leads to irritation. Nurses are frustrated and disappointed and even angry about what is happening (or not happening) in their profession. This was reflected in the views of the participants:

> 'No, I was not really prepared and there was no one to rely on (such as a Saudi female instructor), I had been left to learn by myself. I felt disappointed on several occasions, in particular when a patient needed something that I could not translate' (Lila).

The lack of empowerment reaches into many aspects of a nurse's lived experience. For example, Lila says, 'I wanted to attend lectures and programmes about nursing but there was nothing'. Communication difficulties also cause a significant amount of stress for nurses. Many aspects of nursing—both in training and in practice—use English as the primary language, rather than Arabic. In Sarah's experience:

> 'Even in the health colleges the subjects studied were in English, but the curriculum was not comprehensive anyway and it was insufficient to improve the skills of Saudi nurses that are required for decision making.'

By addressing two key areas, this lack of empowerment can be addressed. These are:

- The contradiction in leadership and
- The unjust financial and other rewards

6.3.2.1 Contradiction in Leadership

There are many contradictions in nursing in Saudi Arabia. On the one hand, people want qualified, capable nurses, yet nursing systems do not seem to promote this. Problems in this area are closely related to inadequacies in leadership and authority in nursing, as explained by Khalid, below:

> 'At that time my aspiration was to help change nursing for the better. I tried to talk with the nursing department and hospital management in order to make the medical terminology clearer and to write the medication in the English language, but no one cared. I obtained no response or support from the nursing department. All they said was, "You're just a nurse." They fought me so I had to move to another place.'

Others said:

> 'I will continue as a nurse if there is good nursing management that can represent my profession, but if they do not care, I am not going to struggle with them … I am ready to work on with a fair administration, but to what extent?' (Rufaida)

> 'The inadequacies of the training programmes were due to the shortage of instructors and lecturers. This varied from hospital to hospital but most of the hospitals and health care centres are lacking Saudi instructors' (Lila).

Organisational development is lacking in nursing. Development and change for nurses must come from leadership and it is not just talk about development that the nurses, or ex-nurses, want. They want real development, as shown in the following quotations:

'We want development. We want to actually feel the development,

not just talk about it. Our experience must be exploited. We face

difficulties and pressures and don't find anyone who is concerned

about us, no one who tries to develop and support the Saudi nurse.

The nursing department must act to develop nursing in all areas'

(Ahmad).

'We don't have plans for nursing. We lack plans because we lack

the competent people who are able to develop nursing. When we

have plans and strategies, the situation will get better. We need

Saudi leaders who are able to effect change and development'

(Waleed).

There are no programmes for development because leadership in

administration does not organise them. Saudi nurses often learn by themselves.

There is a lack of in-service training for both male and female nurses. According to

Zainah, 'most Saudi nurses need to improve their nursing knowledge and skills and

their proficiency with the English language'. And nurses need the opportunities

which strong leadership can create. Waleed said:

'Yes, chances are available. If you know someone, he can transfer

you in no time, noticing that there is a committee at the hospital

which is held to discuss the situation of the nurses who are not able

to practice nursing work.'

As stated earlier, many leaders in nursing are expatriates. Perhaps they are

not the right people to develop nursing in Saudi Arabia. However, currently, Saudi

nurses lack power and authority in their profession. Due to this lack of power, nurses are not be able to effect change and come to a decision about development.

6.3.2.2 Unjust Financial and Other Rewards

The lack of empowerment facing nurses has something to do with rewards. Nurses carry out a vital and important job in the service of Allah, but they are not appreciated as they deserve to be. One way of showing this appreciation and improving the image of nurses in the eyes of the community is to give them the rewards and incentives they deserve. This will help keep nurses in their profession. For someone qualified to work as a nurse, there are no financial incentives to stay in nursing, compared to roles outside the nursing domain. Participants who pushed this point stressed the following:

> 'There is no distinction, when you work at hospital, at an Intensive
> Care Unit or at the Health Centre or in the warehouse. It is all the
> same title, salary and bonus. I feel [an] injustice; this is inhuman
> and affects me psychologically. Even with those working night
> shift, there is no difference' (Sami).

> 'The most important thing is to be comfortable in the place where
> you work. How can I give when I am not happy? Most of the time I
> am upset and tense. There is no one to listen' (Rufaida).

> 'One thing I really want is for the nursing management to be just'
> (Khadijah).

> 'There is no financial reward or anything that can distinguish those
> who are working as nurses. The thank you certificates always go to
> expatriates, but not to us' (Imtinan).

This is supported by Lila and Sarah. They said:

> 'Whether we have graduated from a college or HI, our work assignments are the same. Whether I work in the ICU, medical unit or at the OPD (Outpatients Department) or work during the day or night, there is no compensation. There is no extra allowance even to distinguish employees who have different roles, for example between a head nurse and an ordinary nurse. They each receive the same salary' (Lila).

> 'Salary is not adequate and it is not equal to the effort that we offer. In addition to this, we want more emotional comfort and flexibility in our duties' (Sarah).

Sami said:

> 'There must be some distinction among nurses. Increasing the salaries, decreasing work hours and giving incentives are some of the main reasons to make people interested in nursing. The material and moral incentive is very important in hiring nurses and retaining them in the job.'

From the extracts above, it can be seen that nurses are clearly not happy with their working conditions, their interaction and the incentives offered them for working as nurses.

6.3.3 Paradox of Communication

When providing health care to Saudis, it is important and necessary to speak the language of the society, otherwise deficient or inaccurate communication results. English is the main language spoken in all the health care facilities in Saudi Arabia.

However, most of the patients are illiterate and many nurses are not bilingual. The participants clearly expressed the view that communication is critical for the care of patients and nurses' work performance. Saudi nurses and expatriate nurses face different issues when providing nursing care. Saudi nurses are compelled to become skilled at English and communicate in English if they want to practice nursing effectively, especially in the hospitals, because English is the medium of communication in multidisciplinary health care teams. One of the participants expressed the idea that:

'Poor communication skills made communication in most cases difficult for me. I worked at the chronic cases centre and most of the cases there were cases of old people. I was able to deal with the patient and I assisted the foreign nurse in all procedures made to the patient. Most of the patients cannot express their problems and being close to them solves most of their problems. The Saudi nurse solves many problems involving difficulties in understanding the customs, traditions, language and religion of our country by the foreign nurses. Some Saudi nurses are highly competent and reliable. I wish I was one of them. Nursing needs patience and diligence to learn the cases of the patients and their health status so that their case can be assessed and the treatment they require can be known. Who I am as a Saudi makes me able to understand the nature of Saudi society' (Amlak).

Lila spoke about her problems with understanding the language:

'I experienced some difficulties at the beginning. For example, difficulties in understanding the expatriate nurses as well as my

duties. This often caused problems with the patients, visitors and some of the doctors. Sometimes the patients asked me to help them know what the expatriate nurses were saying. On several occasions, the expatriate nurses asked me to help them translate and explain the procedures to the patients. I am not very good with English and sometimes we called the doctor to explain.'

It is equally important to be able to comprehend both the languages used in nursing: Arabic, because this is what most of the patients speak; and English, which is the language of communication often used by staff in the workplace. This is supported by most of the participants who indicated how vital communication is in the workplace. Waleed stated:

'Starting nursing was difficult, particularly in relation to communicating in English. I was not satisfied with my job status and I decided to continue studying to improve my job and social status. I desired to pursue my study abroad … When I was studying abroad, sometimes I used to find it difficult to express myself because of the language. At that time, I started to feel annoyed and I suffered. This is the same as what happens with the Saudi patients here in the hospitals.'

Other nurses also speak of the language barriers that make nursing difficult:

'Always there is a barrier for us with writing and reading, which requires English' (Khalid).

'I did not participate in nursing work due to my poor English … To participate and work in the field of nursing you have to be good at

English, especially in speech, because if you do not speak good

English, you will not be able to participate … I did not participate

in nursing work due to my poor English … Sometimes the nurses

faced a problem in other words and they asked me to come and to

help them in making the patient understand. Some foreign nurses

used to administer treatment without explaining its nature to the

patient' (Ali).

'I came across many difficulties when I graduated. I was not able

to express what I really wanted because of my inability to speak

English. I found myself lacking the skills required in the practice

… We need to be better equipped in our duties as a nurse …We

need to know the language on which nurses have to rely to work as

a nurse. Most Saudi nurses have really weak English skills. To be a

good nurse, one must master the English language first' (Sarah).

'I had faced many difficulties during practice (at the hospital)

because my studies at the HI were in Arabic. The curriculum was

not sufficient to qualify me to be a nurse. It was only through

watching other nurses, especially in the hospital, that I learned how

to be a nurse. And then the problems were mainly in understanding

the language of other nurses' (Intiman).

At the health college, nurses were taught in English. For this reason, most

graduates from health colleges can participate and make conversation with other

nurses. In contrast, those who graduated from HIs lack the ability to share and

participate. However, according to Imtinan:

'Not all nurses who graduated from health colleges know enough English and because there is no training to improve their language, they found it difficult to continue in nursing. This causes problems for most Saudi nurses, especially new graduates. Most nurses who graduated from HIs were not able to speak English, this made myself and other nurses feel embarrassed in front of the patient. There is no training, if there were English courses, Saudi nurse would benefit and this could help us participate and understand other nurses' (expatriates).

Zainab stressed:

'Language is important; it is important to know English because the majority of foreign nurses speak English. Nursing graduates from HIs face difficulties. One of the difficulties is English and Saudi nurses can't understand the language of the hospital. Nurses lack the knowledge of the English language.'

Lila concluded:

'It took me time to improve my skills before I became part of the nursing team. When I was not able to speak English I did not even think that I was a nurse. Yes, Saudi nurses are in need of intensive training after graduation.'

The above comments indicate that language is a problem for several reasons. Firstly, Saudi nurses speak the native language, Arabic, so they are more likely to provide a better nursing service for their Arabic-speaking patients. Unfortunately,

there are too few Saudi nurses. Secondly, Saudi nurses also need to speak and understand English, as English is the *lingua franca* of Saudi nursing.

6.3.3.1 Paradox of Change

It was stated earlier that there is a lack of organisational commitment in nursing and contradictions in leadership. Further, a lack of development was mentioned and this will be explored further under this theme. All of these issues are related to change. Change is essential in all professions to improve their services and keep pace with changing trends in other professions and in society. Certainly, in nursing, change is vital. However, many of the participants reported serious contradictions in change in nursing. Lila explained that:

> 'The Saudi government has adopted sophisticated technology and hospitals have new and modern equipment. New technologies are introduced on a regular basis and we need to be informed and brought up to date on these … There are no development programmes to improve the nursing skills required and to keep nurses fresh in their practice.'

Many of the nurses interviewed spoke about a need for better training and further training.

> 'The most important step is to improve the job standard of the female nurse and to support and encourage her and fulfil her interests. Conducting intensive courses, opening the field for continuing study and developing the work level are all important steps. Most importantly, observing the social circumstances of the female nurse. There are some Saudi nurses who are unable to make

ends meet between home duties and job. Circumstances of the
Saudi woman must be observed and work hours must be
minimised' (Amlak).

'I hope that training courses and lectures improve. Nurses need to
be able to update their information and to learn new things. Most
females do not know enough about the role of nursing because we
lack information through the media such as the radio, TV and
newspapers' (Norah).

'There should be lectures and cultural programmes to promote
nursing and the functions and roles of nurses. Nurses should have
the opportunity to exchange experiences with colleagues so that all
nurses, including newcomers, can help each other' (Khalid).

'There is no development or lectures and there are no programmes
which nurses with their different nationalities can benefit from …
Nursing departments in the Kingdom as a whole must be re-
evaluated and restructured … First of all, we must focus on
education' (Ali).

In looking at nursing education overall, the subject of language cannot be
ignored. Aisha said:

'As for the language, without practicing it will be useless. It is not
easy to learn English and we acquire the language with time.'

Imtinan expressed the need for wide-ranging changes:

'We need encouragement as well as training; the most important

problem is the long working hours which made the life of Saudi

nurses hard to endure. The image of nursing must be changed so

society can accept the profession.'

Job standards, training courses, the promotion of nursing in the eyes of the

community, the restructuring of nursing departments and a new focus on change in

education are among the recommendations for changes needed. As well as this, Sami

pointed out one way to have better trainers and supervisors in nursing:

'A plan must be set for 20 years into the future. The nurse who

works ten years as a nurse must not continue work in the

departments and we must benefit from his experience in another

field such as training, education, supervision, management or other

programmes so that he can have a role in developing and

encouraging new nurses.'

There is also a need for better understanding, but first there must be improved

communication. It is obvious that Saudi nurses struggle with communication. It is a

major challenge for them to learn the concepts of nursing care from different

theoretical perspectives in their non-native language. As long as Saudi nurses are

required to master the English language to understand the concepts involved in

nursing, communication barriers will persist and the meaning of the concepts will

often be misunderstood. Therefore, we need change. However, enacting change,

especially in relation to problems of communication, is a complex process and is

linked to the other paradoxes. The paradox of education will be discussed in the next

section.

6.3.4 Paradox of Education

It is evident from the perspectives of the participants that educational improvements are vital if Saudi nurses are to receive adequate training. Despite this, change does not appear to be forthcoming. At the time of this research, there were two different systems of nursing education in Saudi Arabia, each with its own authority. These systems are not linked to each other as an integrated system and they do not work together to improve nursing education in general. In this research, Saudi nurses employed, or previously employed, in MOH facilities were interviewed. These nurses may have graduated from HIs or health colleges. HIs were developed when nursing education began. Thirty years later, they were followed by the establishment of health colleges. However, now all the HI programmes are available in health colleges and have been taken over by the Ministry of Higher Education (MOHE). According to the nurses interviewed, the education in both HIs and health colleges needs to be improved. Some of the comments of participants include:

> 'Education and culture are important things in nursing, but
> education is ignored. We don't give nursing its right educationally
> and culturally. We need changes' (Ahmad)

> 'The problem is that the study is very theoretical' (Reem).

Lila supported the above statement and said:

> 'Initially study was difficult for me because it was in English. All
> the teachers were from the neighbouring Arabic country and most
> of them used Arabic terms in order to facilitate understanding. The
> curriculum lacked proper communication that was needed to

improve our knowledge and skills. The study was theoretically

based, but some of the subjects were not really relevant, while

others were not taught adequately. I was always looking for

someone to help me because there were no resources available in

the health college.'

All of the nurses interviewed agreed that the need for changes in nursing

education was essential. Expatriates are not nursing as well as Saudis are able to,

necessitating an increase in the number of Saudi nurses employed. However, as the

participants pointed out, it is not easy to get the training that is required.

The nurses said much on the topic of education and made many comments

about the lack of a suitable education in nursing. In collating the participants'

comments on this topic, I have sub-divided the themes further.

6.3.4.1 Lack of Educational Opportunities in the Nursing Profession

Even though more institutes are being opened, Amlak pointed out that it is

still difficult to get into nursing:

'Now it is difficult to be accepted in nursing colleges. It is required

that you score good marks at secondary school and the nursing

colleges accept only those who studied in the scientific section.

When the girl graduates from the secondary school scientific

section, she will find the way open in front of her to join medicine

or nursing.'

Further, there are not enough universities that teach nursing. Sami said:

'Other causes of problems include limited education opportunities and non-opening of universities and limitations of admission to only a few numbers in the Kingdom. We know that the nursing constitutes 80 per cent of manpower in the hospitals, so we look forward to developing education because if conditions continue as they are, we will need 100 years to cover the shortage of nurses.'

Similarity, Zainab stated:

'I hope to continue my studies and get a Bachelor degree, but this is difficult because Bachelor degrees do not exist in our city at the College of Nursing. It is hard to travel anywhere else to study. There is a problem when the female nurse wants to continue her education and there is a shortage of universities.'

Ahmad and Waleed reinforced the ideas of the other participants, concluding:

'The policy of education is very bad and needs to be reconsidered. The small number of universities and their limitation to only three regions does not give the opportunities to most girls to study nursing due to the difficulties girls face in moving. Saudis are not provided with enough opportunities and not properly directed. The nursing department must be adapted by someone who cares about upgrading and developing nursing' (Ahmad).

'The objective of the MOH was just to open institutes and to increase the number of graduates and no attention was paid to academic performance. Now there are more male nurses, most HIs have been closed and replaced by health colleges' (Waleed).

Ali agreed with Ahmad and Waleed. He said:

> 'The number of universities should be increased and a bachelor
>
> degree should be made available.'

Lila added that 'as Saudis, we need time to develop, but not without courses and resources'. There are not enough native nurses in Saudi Arabia, but even if there were, the facilities to train them to a high level do not exist. Instead, the MOH suggests the private sector opens up more HIs and colleges. This might create more graduates. However, as with previous HI and college graduates, these graduates will be unqualified due to the poor quality of training and the problems in the workplace will increase. As has already been shown, when nurses are not taught to do their job properly, their job satisfaction suffers, prompting them to leave the profession. As such, poor education runs counter to the policy of Saudisation.

6.3.4.2 Inadequacies of the Education System

HIs and colleges are not providing adequate training, according to comments from nurses like those above, and the following from Khalid:

> 'Initially we were fearful of work as a nurse due to our lack of
>
> ability to communicate (as the language barrier is the main cause
>
> of non-ability to practice nursing in hospital) and less skills. But,
>
> yes, I think that the HIs prepare or qualify you to work only at the
>
> health centre … I felt that the HI didn't qualify me for working in
>
> the hospital; how can I become a nurse while I am weak in
>
> communication and lacking nursing skills. There was no
>
> supervision or assistance after graduation. If you don't struggle and
>
> improve yourself, you will not be able to work … I have worked

for six years in health centres after graduation from a HI, and then

a Health Sciences college. During my study in the college, I felt

that I learned much because the teaching language is English and

the knowledge base of the subjects was higher than it was in the

HIs.'

The standard of training is obviously an essential element to consider in reforming nursing education. Some participants expressed this as follows:

'My experience made me understand the weaknesses of the

educational standard prescribed for the Saudi nurse at the HIs and

colleges and I now understand we don't have the resources in

Saudi Arabia which are able to raise the standard of nursing skills'

(Waleed).

'Even the use of some tools was taught erroneously' (Khalid).

'I benefited little from my study at the HI, as it was not enough'

(Sami).

'Really, the study was not sufficient and we often studied subjects

that had nothing to do with nursing, or with what nursing was

really like in hospitals … My benefit from study in the institute

was very small. We were not given enough information about

medical terminology or medical principles. The study was in

Arabic and a little in English' (Ahmad).

As Waleed pointed out, at the HIs, study is in Arabic and the subjects nurses studied are not sufficient for understanding nursing. Sarah explained that she was unable to compensate for her lack of technical knowledge by learning in the hospital:

'Responsibility for nursing practice must be established. A contact

person for the training of nurses needs to be considered and they

need to be a Saudi nurse. When I was practicing nursing as a

trainee, the foreign nurses tried to teach me in front of the patients.

During the process of giving medication, for example, if the patient

required an injection the foreign nurse would teach me the position

of the needle in front of the patient. Then the patient would not

allow me to inject her because she was afraid. I am still learning.

On several occasions some patients said, "If you are learning I

really do not want you to practice on me"' (Sarah).

Many of the nurses made comments like this and it seems clear that both

more effort, as well as more money, needs to be spent on nursing training and the

development of nursing courses.

6.3.4.3 Inadequacies of Private Institutions

There are private institutions that teach nursing. However, these are also not

sufficient in the training they do. Waleed said, 'now, the main problem we have is

related to graduates of the private institutes.' Even though the government allowed

the private sectors to open up health colleges, there was no relationship between

these colleges and the needs of the nursing profession. There is a lack of an adequate

and uniform standard in policy, education and training among these institutions. In

the private institutions, according to Waleed:

'The standard is low and they do not have the necessary skills.

Language is also difficult for them. I think that study at the private

institute was of a lower standard than that at the HIs affiliated with

the MOH … Nobody is responsible for supervising students of the

private institutes and the hospital is not responsible for them. What

happens to them today resembles what happened to us at the time

of study at the HI. Private institutes do not have special nursing

curricula and people just follow their individual efforts and collect

the books. The teacher in the private institutes prepares the

curricula himself … Ten days ago, one Saudi nurse applied for

work as a nurse affiliated to a company contracting with the

hospital. They assigned me to test him. Believe me, he didn't

answer correctly any question about nursing, although my

questions about nursing were general and they were not difficult.

He even tried to answer some questions by accessing his mobile.'

Therefore, it seems that the private institutions, like the HIs before them, are

not educating their nursing graduates to a high enough standard. Waleed is just one

nurse who points this out. Further, his indication that supervision is inadequate is in

keeping with comments from other participants regarding the inadequacy of

supervision in the HIs and health colleges.

6.3.4.4 Unqualified Supervisors

The theme of unqualified supervision and unqualified teachers emerges from

most of those interviewed. Some comments include:

'Regarding the practical training we were given, there were no

trained supervisors and no clear plan of learning that we could

depend on. We felt that practical studies were unimportant and that

we could not depend on ourselves or our training' (Ahmad).

'My course of study was not good enough … those who taught us were not academically qualified and they lacked nursing experience … The practical work supervisor didn't do anything. He just took care of attendance, and time of leaving the Institute. Nobody cared during the practical training and students just depended on their own abilities … the supervisor was careless … Qualified people should be made supervisors in order to improve the status of Saudi nurses' (Ali).

'When I started practicing nursing, there were no supervisors or teachers and foreign nurses did not assist Saudi nurses. They knew that Saudi nurses were "not well-prepared to work". Many of the foreign nurses said that "Saudi nurses are receiving more salary than us so they should work harder than us"' (Zainab).

'The practical training was not good enough and there were no supervisors capable of giving good guidance and education. There is no supervision from the place where we are trained, whether at the Hospital or in the Health Centre. The role of the supervisor affiliated to the institute was to take care of attendance' (Waleed).

'[The] study depended on old study programmes, while some teachers were just physicians. The practical application period during study was not sufficient and training lacked supervision. No one directs assists or supervises the practical application in hospital or health centres—we must just learn by ourselves' (Khalid).

The following account by Zainab gives some insight into the lack of capable teachers and supervisors:

'The study at the college was three years and it was in English, but

I had graduated from the health college as a nurse. Although the

nursing programme was taught in English, it was deficient because

there was a lack of references. Most of our teachers who were

teaching us in English were native Arabic speakers and when

something needed more explaining they would explain it in Arabic.

I did not learn a lot because the curriculum was not all-inclusive in

Arabic but involved English and it lacked practical application.

During the exam, we were required to memorise English words

even though we didn't understand their meaning.'

It is clear from the statements made that nursing education needs to be taken more seriously and that better, more qualified teachers and trainers should be found. Sami sums up the situation, saying, 'the nursing department throughout the Kingdom lacks the right people.'

6.3.4.5 Lack of Preparedness after Graduation

It is not right that nurses should depend mostly on their own resources and efforts to learn about nursing. However, Ali and Ahmad are just two of those interviewed who state this to be the case:

'The purpose of this six month term [practical experience] was to

provide an opportunity to new nurses to become familiar with the

nature of the work and to upgrade their skills. But because of the

lack of supervision and guidance, the practical term depended on

the student themself, so some people benefitted from this period while others didn't' (Ali).

'When we are trainees, the period is limited and it is not adequate to improve our nursing skills. Not all that we need to learn can be taught in practice. Because of the lack of nursing instructors, especially Saudi instructors, the only one who supervised us in our practice was our teacher' (Sarah).

In addition, Sami said:

'I was not prepared academically, technically and morally.'

And Lila said:

'We as nurses didn't realise the gap between what we learned and what we needed to learn until we found we did not really know what to do. The improvement of our nursing skills required resources but we did not have them. We always needed development courses but unfortunately what nurses required for their profession was not available yet. Most of the equipment used, especially in ER and ICU, is labelled and has explanations in English. To use them required nurses to understand the language. Therefore, we did not know how to use most of the equipment.'

Faten explained:

'Yes, when I started working, I encountered so many difficulties as a result of not knowing English, but thanks to God I gradually overcame most of these difficulties. I learned English through

talking with an Egyptian doctor … the expatriate nurses did not teach us for fear of us taking their positions. '

And Rufaida added:

'Our theoretical study is not enough, we need more practice and courses to improve our skills. After graduation, I had six months training. This training programme was for new graduates to learn a list of procedures in different areas. For example, we spent one month each in the surgical and medical unit, ER, ICU, etcetera. Since no one was in charge of this training, there was no one to supervise me or to evaluate my learning at the end. It was useless and I did not benefit from it. As a new nurse, in each unit of practical training, the head nurse usually let me do ordinary work such as monitor vital signs and help other nurses to clean the patients.'

Others explained:

'At first we had difficulties, particularly with the medical terminology that we did not know' (Aisha).

'I have come to understand the real role/function of the nurse through practicing and performing the job. About 60 per cent of my nursing knowledge came through practicing and my own personal endeavours' (Ahmad).

'The study was somewhat simple and information on nursing and its skills was not enough and not comprehensive. We used to gain the skills through practicing at hospitals … I learned most matters

myself through watching the work of the foreign nurses … I was not ready and there was some fear at the beginning, but I felt that I was responsible and tried to improve my skills. Having some difficulties along the way helped me to depend on myself. We were not prepared and we did not benefit from the practical work, and learned skills during work and through our personal efforts … [we were] not trained properly about the role of the nurse and the work assigned to her. In the beginning, I was not psychologically or academically prepared' (Amlak).

'We didn't have nursing skills and not enough care was taken in training nurses and people were not serious about developing nursing' (Sami).

'During study, we didn't know what we would be like as nurses when we graduated. This was left for us to discover alone when we became nurses … By the time I passed the first year, I felt that nursing was strange and that it wasn't compatible with our tempers, customs and traditions. I was ignorant of what nursing really is … Nurses didn't know enough when they completed their studies' (Ahmad).

Lila expressed similar views. She said:

'No I wasn't ready for practicing nursing and I was the same as other nurses who needed more training because medicine always evolves, always new things are developed … When I started nursing practice as a new graduate, I was shy, my language was not

sufficient. I usually carried a dictionary to help me, so I kept

learning English and asking expatriate colleagues for help. Most of

us did not really know how to pronounce the English words

properly. This was often the same for expatriate nurses who spoke

English as their second language.'

Ahmad explained:

'I felt that I was just a servant and that I couldn't be a nurse

because I didn't know enough. If I don't know the job, how can I

do it? I felt no desire to continue studying and tried to quit. I

actually did leave for three weeks, but my father and some

colleagues encouraged me to return. I think because I was young—

just an adolescent—that I refused to do some practical studies that

involved things like a lot of blood or critical injuries. Some

students left their studies due to the critical cases they were

involved with and sometimes we had to deal with a patient who

kept us busy for the whole day' (Ahmad).

In Saudi Arabia, we need qualified Saudi nurses who can best relate

to their Saudi patients. However, from the comments made by the nurses

interviewed, it is clear that nurses are not being properly trained, so that after

graduation they are not prepared for nursing. When graduates are not

prepared adequately for nursing after they complete their courses, their

experience of nursing can become a negative one, as indicated by the

comments above.

As well as deficiencies in university level training, there are a lack of

opportunities for practicing nurses to continue their education and participate in

professional development activities after graduation. One reason for this is the inadequate provision of short courses for practicing nurses. A number of participants raising this point:

'There is an important issue I need to tell you about. When there is any training to be held in the hospital, it is always the expatriate nurses who will be selected. I worked with four female Saudi nurses at the hospital for more than 3 years and we never had any training and were never selected to attend or participate in any courses. The training courses were arranged by expatriate nurses for them, but not for us. The expatriate nurse is the one who is usually selected to attend and participate in such courses and we were left aside' (Rufaida).

'Yes, there are training courses for the nurses, but most of them are informal. Some of the courses are held in English and therefore hard for us to understand; when I attended these courses, I did not understand what was being said. We want more courses and first we want courses which teach the Saudi nurses English. Likewise, there should be courses for the expatriate nurses in order to learn the colloquial Saudi language so they can manage to understand the Saudi patient's needs. Because of the lack of understanding of the Arabic language, expatriate nurses often face many problems' (Aisha).

'Most of the courses available to us are not recognised' (Khadijah).

Some of the above complaints have been mentioned before, like the lack of courses available for nurses. However, it was felt to be important to mention them again here as a reminder of the neglectful attitude of nursing authorities towards the Saudi nurses who they are supposed to be assisting. Saudi nurses, when they are not prepared for nursing because of inadequate education, training and support, do not remain nurses for long.

6.4. Conclusion

The experiences of the participants in this research offer insights into the lives of Saudi nurses and into their problems and needs. As has been shown, the experiences voiced by the Saudi nurses in these interviews have neglect as a major theme. To classify the extracts collected through the interviews, the two major themes of 'Sociocultural Factors'—relating to external pressures that Saudi nurses face—and 'Organisational Paradoxes'—relating to problems within the internal structure of the nursing profession—were used.

Regarding sociocultural factors, nurses refer to the cultural background and social pressures that make nursing as a profession difficult. They portray social support and organisational commitment as lacking in nursing. Inadequate support from family and society is frequently commented on. The participants also indicate confusion, due to apparent conflicts between being a Muslim and being a nurse (specifically, the 'mixing' issue). Misinformed attitudes of Saudi people towards nursing is a major theme—many of the nurses do not consider mixing to be a problem, but do comment on having faced pressure due to society's negative perception of mixing in nursing.

Female nurses especially cannot feel comfortable working long shifts and neglecting their families. The prolonged conflict between the role of nurses and

Islamic teaching remains unresolved. Working conditions are also causing continuing problems. An undesirable working environment, coupled with long working hours, reduces the satisfaction of Saudi nurses and may dissuade those thinking of becoming nurses. Further, reduced satisfaction levels are prompting nurses to leave their profession.

Regarding Organisational Paradoxes, the commitment of nursing organisations towards nursing education, practice and management does not reflect the cultural values and principles of Islam. Nursing organisations do not concern themselves with issues involving Saudi nurses, such as the social conditions of female nurses. There is a lack of support, bordering on neglect, from nursing management.

Moreover, a contradiction in leadership, unjust financial and other rewards, problems in communication because of the language of nursing and inadequacies in the nursing education system are further contributing to the number of nurses leaving the profession. As the participants have shown, educational opportunities are lacking in the nursing profession. HIs and colleges are not providing adequate training, in part because of unqualified staff and supervisors. Nurses are simply not prepared for nursing after graduation and once in nursing they are not supported and encouraged to continue in nursing.

Another significant issue raised was the lack of understanding of the culture of the nurses by management (almost exclusively expatriates). All the participants in this research raised the issue of inequity and injustice in the workplace, explaining that non-Saudi nurses held much more power in Saudi nursing. The Saudi nurses attributed this to their lack of access to appropriate education, training and skills, which they saw as perpetuating their lack of power in the workplace and as hindering

them significantly in developing in their profession and providing quality nursing care.

Overall, the lived experiences of Saudi female and male nurses reveal neglect. Most participants have indicated they do not or did not find satisfaction in their profession and they continue to view the standard of nursing as a profession in Saudi Arabia as in a critical condition. It is therefore not surprising that Saudi nurses are leaving their profession, despite the programme of Saudisation pushing for more Saudi nurses in the workforce.

A major contributing factor to this dilemma is that nursing management in Saudi Arabia has been established from a non-Saudi perspective and has not integrated Saudi culture or religious considerations into its development. As a result of this, the needs of Saudi nurses are not being considered in management decisions.

This is only one among many contradictions identified in the participants' interviews. In addition to the lack of social support, the findings presented here suggest instability within the education, practice and management of the Saudi nursing profession. Further, the nursing organisation in the MOH has been found to be unable to educate, train, manage and attract Saudi nationals. It is now important to return to the literature to contextualise these findings.

Chapter 7: A Return to the Literature

'A nurse is a symbol of caring, a dream of being tended by a nurse

may be compensation' (Dale, 1997, p. 408).

7.1 The Emerging Image of Saudi Nursing

This chapter returns to a review of the literature, this time in relation to the findings. The factors that concern Saudi nurses can be grouped according to the following framework, which provides much of the structure of this chapter.

Table 7.1

Classification of the Major Themes

Sociocultural Factors	Nursing Literature
Contradiction in the Value of Caring	Cultural Competence/Contradiction
Attitude of the General Population	Nursing Image
Conflict with Social Structure	Lack of Proper Management
Organisation Paradoxes	Nursing Literature
Paradoxes of Organisation Commitment	Nursing Authorities and Frameworks
	Environmental Barriers
	Saudisation in the Context of Saudi Nursing
	Recruitment and Retention
Lack of Empowerment	Working Conditions
	The Concept of Sustainability
	Organisation Development
	Professional Identity and Saudi Nurses
Paradoxes of Communication	Barriers of Communication
Paradoxes of Education	Suitability of Nursing Education System
	Professional Assessment

Overall the themes emerging from the findings relate to sociocultural factors and organisational paradoxes. The findings of this research clearly indicate there is a clash between the actual lived experiences of Saudi nurses and what is expected of them by the nursing system. The government and the Saudi people expect an efficient, healthy nursing system, but contradict this by not adequately caring for the needs of Saudi nurses. This is revealed by the fact that nurses have not been trained to a high standard (Tumulty, 2001a). Further, nurses have not had enough practical experience before they practice and they do not have representation in nursing bodies (which are not encouraged in their profession).

Until recently, Saudi nurses practiced without registration, and they still have no professional standards or guidelines to adhere to. Now, upon graduation, nurses are required to be registered and demonstrate continuing competence if they are to maintain their registration in the profession (Nasrabadi & Emami, 2006). Indeed, Saudi societies expect proficient health care from nurses. The Saudi people, as well as organising bodies, expect nurses to use correct processes and safe practice in providing holistic care for their society. However, minimum standards have not been established.

The proportion of individuals entering the nursing workforce holding a degree has been insufficient since 1976, given that 67 per cent of Saudi nurses are diploma holders only (Abu-Zinadah, 2006). In Saudi Arabia, the demand for degree qualifications is considered high. This is supported by a Federal Advisory Panel, which has recommended that at least two-thirds of the basic nursing workforce should hold a baccalaureate or higher degrees in nursing by 2010 (National Advisory Council on Nursing Education and Practice, 2003). Tumulty (2001a) found training and education to be a challenge for nursing in Saudi Arabia. The nursing education programme for Saudis has not kept up with current skill and competency

requirements. This explains the deficiency in the essential components of a profession that is education based.

Nursing training is difficult for Saudi nurses. Not only is their logical understanding different to that of those who have created many of the nursing frameworks, but to fulfil all workforce requirements, Saudi nurses must be fluent in English to the extent that they can understand nursing practice, including all terminology and medical language.

Allen, Chapman, O'Connor, Bullwinkel and Francis (2007, p. 51) state that the relationship between the nurses' languages in a particular group 'does promote power and authority'. In Saudi Arabia, the nursing language is not the Arab language of Saudi nurses and for this reason language does not support Saudi nurses, but creates a barrier and discomfort for them in understanding their tasks. In 2007, the WHO estimated that 61 per cent of the health work force of Saudi Arabia are expatriates. The latest statistics from the MOH (2008) indicate the total number of nurses in KSA to be 83,868. Out of this, 22,744 are Saudi nurses (27.1 per cent). It is possible that all these nurses struggle with language issues.

Table 7.2 represents the total number of nurses working in Saudi Arabia. The total number of nurses in the MOH is 44,395, of which 31,912 work in hospitals. However, the number of Saudi nurses is 10,417 (33 per cent), which comprises 4,897 females and 5,520 males. The total number of nurses working in PHCCs is 11,170. Of these 4,110 are non-Saudi. The ratio of all nurses to Saudi people in the PHCC is 4.7:10,000 (MOH, 2008).

Table 7.2

Total Number of Nurses Working in Saudi Arabia

	Nursing Workforce	Saudi Nurses	Males	Females
Total Number of Nurses	83868	22744		
Number of Nurses in MOH Hospitals	44395	10417	5520	4897
Other Government Hospitals	20488	3581		
Private Sectors	18985	719		
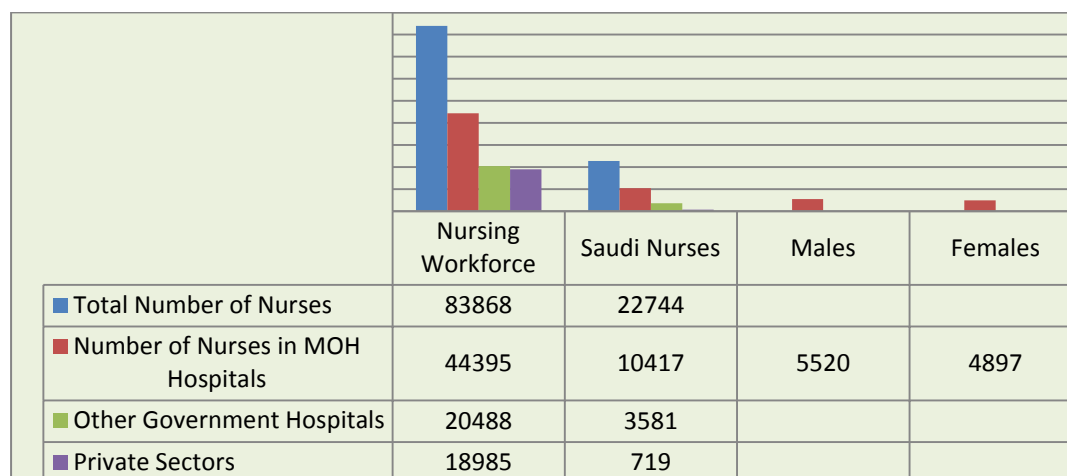
In other government health sectors, such as the National Guard and the Military, the total number of nurses is 20,488, of which 3,581 nurses (17.5 per cent) are Saudi. In the private sectors, there are 18,985 nurses, of which only 719 are Saudi. The total number of nurses working in private hospitals is 11,664, and only 498 are Saudi nurses. In the private health centres, there are 7,321 nurses. Of these, 221 are Saudi nurses (MOH, 2008).

Table 7.3 (below) looks at the education level of the Saudi nurse workforce in 2006: 67 per cent were diploma holders (HIs or colleges of technology), 30 per cent held an associate degree (health colleges) and 3 per cent were BSN graduates (colleges or universities). Further, only 28 graduates held a Master's degree, with another 7 having a Doctorate as their highest qualification (Abu-Zinadah, 2006).

Table 7.3

The Education Level of the Saudi Nursing Workforce

Nursing Education	%	No.	Qualifications
Health Institutes	67%		Diploma
Health Colleges	30%		Associate Degree
	3%	-	BSN
Universities	-	28	Master Degree
	-	7	Doctorate degree

Source: Abu-Zinadah, 2006.

As shown in Table 7.3, the level of education of Saudi nurses varies. So too do their perceptions and issues. In the next section, the concept of professional identity in nursing is discussed to begin to understand how nurses view themselves and their profession.

7.2 Contradiction in the Value of Caring: Cultural Competence

The findings indicate that culture cannot be separated from nursing in Saudi Arabia and that Saudi nurses need to be trained in culture-specific health care and be culturally competent. Luna (1998) argues that culturally competent health care is a challenge for nursing in Saudi Arabia, given that many of the patients are native Saudis (and Muslims) with specific cultural and religious influences on their lives.

Cultural competence means having the beliefs, knowledge and skills necessary to work effectively with individuals different from one's self, knowing that issues of social justice cannot be overlooked (Krentzman & Townsend, 2008; Leininger & McFarland, 2002). Cultural competence is further determined by the ability of the individual and an organisation to work with others within the context of their cultural beliefs (Andrews, 2008; Jeffreys, 2006). This is relevant to nursing in Saudi Arabia for a number of reasons; not the least of which is the fact that 'a health

provider cannot be culturally "competent" in a second culture unless he or she grew

up in it or is at least fluent in the language' (Meleis & Lipson, 2004, p. 70).

7.3 The Attitude of the Population: The Nursing Image

Nursing education in Saudi Arabia has experienced some development, but it

is still a profession with a social stigma attached (Miller-Rosser, Chapman &

Francis, 2006). The low image and status of nursing, as well as traditional and social

values, have been identified as major inhibiting factors affecting the Saudi nationals'

reluctance to enter nursing (Jackson & Gary, 1991).

Saudi Arabian nursing has traditionally not been held in high esteem in the

country; from the perspective of Saudi nurses, the public sees nursing as an

objectionable profession. The poor image of nursing as a profession in Saudi Arabia

and the cultural opposition towards female employment have contributed to the

continued reliance on expatriate health care workers (Brown & Busman, 2003;

Jackson & Gary, 1991; Tumulty, 2001a).Saudi nurses, both male and female, face

many barriers in choosing nursing as a career (Miller-Rosser et al., 2006; Tumulty,

2001a). Nursing suffers from a negative image in Saudi society due to cultural and

religious beliefs and practices (Gazzaz, 2009). In addition, the education of nurses is

seen as being inadequate to deliver quality health care (Aboul-Enien, 2002; SPA,

2004; Tumulty, 2001a).

In the literature, there are two important factors influencing nurses' desires to

promote professional competencies. First, the unfortunate image of nursing within

society reflects the lack of knowledge of nursing in many societies in the developing

countries. Second, the same poor image is held even among other health care

professionals (Arbon, 2004; Catalano, 2000; Schwirian, 1998).

The expectation of nurses in Saudi Arabia in the past was that they would just attend to ill patients and provide ordinary health care. These tasks seemed to be of low status and an unsuitable career choice for Saudi people (Tumulty, 2001a). This, combined with the negative view of nursing in the community, has led to a view of nursing as a job for maids or uneducated women (Miller-Rosser et al., 2006).

While there has been university education in nursing available for women since 1976, university programmes in the Kingdom have historically had low enrolment because of the poor image of nursing compared to other professions (Tumulty, 2001a). There is little motivation for a Saudi to embark on a nursing career. Therefore, university programmes are having difficulty recruiting women to nursing. Although the College of Nursing at the National Guard Hospital appears to be an exception as approximately 2000 applicants apply each registration, possibly due to the reputation and the pay of the National Guard. Adding to this is the fact that nursing demands long working hours, while providing inadequate financial reward (Jackson & Gary, 1991; Tumulty, 2001a).

Many Saudi secondary school students have not even considered nursing as a possible career. The attitude of high school students towards the nursing profession in Saudi Arabia is revealed in a study conducted by Al-Omar (2004) in Riyadh. The result indicates only 5.2 per cent of 479 respondents were interested in nursing as a future career. Some prominent reasons that Saudi females did not choose nursing as a career included the image of nursing in the community, the image of nursing within their families, cultural and communal values, long working hours, mixing with members of the opposite gender and the worry of becoming unmarriageable because of both the stigma attached to nursing and the unsatisfactory working conditions.

Jackson and Gary (1991) found that nursing was ranked last as an appropriate occupation for women. According to Tumulty (2001a), the type of work, inadequate financial rewards and working hours were the reasons for this low ranking. Working hours for married Saudi women, with their family obligations, does not equate well with the hours of nurses' shifts. Nursing suffers from a poor image in Saudi society, but Saudi men who choose nursing also face criticism from family and friends (Miller-Rosser et al., 2006).

Members of the Saudi medical profession also hold negative views of nursing. According to El-Sanabary (1993, p. 1339), Samurai Islam, a former dean of pharmacology at King Abdul-Aziz University, cited evidence from her professional experiences that although doctors spend their first academic years in the same classes as female nursing students, they then consider them to be inferior, less intelligent and less capable.

Historically and currently in Saudi Arabia, the nurse's role has been viewed as an extension of the physician's role. A significant concern is that those who graduate as nurses may not be proud of their profession and may not remain in the work force (Jackson & Gary, 1991). Saudi nurses distance themselves from nursing because, in addition to gender and family issues, 'nurses are viewed as subservient to the physician and … a second-class citizen in a culture where honour is strongly linked to status' (Carty et al., 1998, p 36).Therefore, social and professional issues are strongly linked. Half of the graduated nurses leave the profession soon after commencing work as nurses (Abu-Zinadah, 2006).

Some people believe on religious grounds that Saudis should not be nurses. These people simply do not understand the idea of nursing and its significance from an Islamic point of view. Viewing nursing from just one perspective creates an oversimplified standardised image of people and groups. As people look at nursing

from a central religious perceptive, they often ignore the positions of individuals in society, both males and females. For instance, when men show interest in nursing, they are told that nursing is a female task and that Saudi males are not supposed to work in the domain of females.

The identity of being a Muslim is complicated. The identity of being a Muslim as well as being a nurse has not been maturely linked to the profession of nursing. It should be. If being a Muslim means you cannot be a nurse, then Saudi Arabia will never have the health care it needs. This is contrary to Muslim beliefs, in which caring is a significant aspect of being a Muslim (Al-Shahri, 2002; McKennis, 1999; Rassool, 2000).

7.4 Conflict With Social Structure: Attractiveness of the Role

'If you are not part of the solution, you are part of the problem'

(Kossman, 2009, p. 55).

Health care in Saudi Arabia is at the forefront of Saudisation policies. Changes are taking place. However, the image of nursing needs more attention. This image has much to do with cultural and religious values. Only recently and with 'limited relaxation of cultural beliefs' have Saudi women sought employment (Miller-Rosser et al., 2006, p. 2). Prior to this, Saudi Arabia relied on attracting expatriates to the country in large numbers through the lure of high salaries and travel. According to Miller-Rosser et al. (2006, p. 2), recent threats of terrorist activity and uncertainty throughout the Middle East have combined with a global nursing shortage to make the need to train Saudi nurses urgent as the ability to attract expatriates diminishes.

The image of nursing is connected with the traditional and now changing values and cultural beliefs of Saudi people. This needs to change and nursing

organisations need to be ready to promote nursing. Saudi women are slowly starting to be employed as doctors, nurses and allied health workers. However, Saudi females who choose nursing as a career face still many obstacles (Doumato, 1999; El-Sanabary, 1993; Miller-Rosser et al., 2006; Tumulty, 2001a). Nursing needs to be promoted as a culturally acceptable career and as a profession that is important to Saudi Arabia. Indeed, quality nursing has been identified as a condition of the delivery of a safe, high quality and cost effective health care system (American Association of Colleges of Nursing, 2008).

Nursing intervention impacts positively on the quality of health care. However, the success of this intervention depends on the quality and extent of the nurse's education, the nurses' workload, the nursing experience and nurses' skills; all of which are linked to the work environment (Bowling, 2002; Johnson, 1992; Joel, 2006; Huber, 2006). As demonstrated by the research findings presented in the previous chapter, the nursing environment needs to change. Once the nursing environment changes, the perception of nurses will follow.

Lack of knowledge and information about the nursing profession were key issues in forming a negative perception of nursing among high school students (Al-Omar, 2004). To make nursing more attractive, there is a need to educate the public about the changing role of nursing, the professional skills required, the opportunities for leadership for university-educated nurses and the availability of work (Al-Hosis, 2010;Tumulty, 2001b).

7.5 Paradox of Organisational Commitment

7.5.1 Nursing Authorities and Frameworks: Contradiction

The reality of education, training and the management of the nursing profession by the MOH and the MOHE is another area in need of improvement. These organisations might give more power to nursing bodies. However, unfortunately, these authorities are not closely aligned with the needs of nurses. There are inadequate interconnections between the nursing council, nursing administration and educational institutions. Since the establishment of the nursing profession, higher education has been the domain of the MOHE, while other levels of education have been in the hands of HIs and health colleges, which offer diploma and associated degrees undertaken through the MOH. Recently, the MOHE has taken over all aspects of nursing education (Al-Hosis, 2010) but it is too early to tell whether this move will have a positive effect on the preparedness of Saudi nurses to take more responsibility in and for the nursing profession.

Currently, there is no clear understanding of the minimum standards of knowledge required of nursing graduates. Setting these standards should be the responsibility of the Nursing Council—this is the desire of nurses who participated in this research. The establishment of a set of guidelines such as this would begin to address the dissatisfaction of nursing graduates with their level of education. As described by most of the participants in this research, the majority of nurses who graduated from HIs and health colleges in Saudi Arabia have not been happy with the procedures for obtaining their licences: the theory test required to pass their exam has been designed for another country (and assumes that teaching has been far more extensive), rather than being based on what has been learned in Saudi nursing schools and practiced by Saudi nurses.

Conversely, nursing education at the MOH is incapable of supporting nursing practice due to the lack of a good organisational base. In the most recent official statistics, the weakness of the nursing programmes is clearly shown in the gap between the education, training and practice in the nursing profession (MOH, 2008). Most of the 60 per cent of Saudi nurses in the workforce have graduated at a diploma level, which is below the ICN recommendation.

It has been noted that the education systems in the MOH are not capable of supporting the nursing profession, primarily due to the conflicting issues in relation to the training of Saudi nurses (Aboul-Enien, 2002; El-Sanabary, 1993; Tumulty, 2001a). Nursing organisations in Saudi Arabia think that it is their responsibility to adapt and establish a nursing programme and put it into practice for Saudis without enough careful consideration of what Saudi nurses need to know. This even extends to such critical areas of nursing such as ICU, ER and midwifery practices. It is a good idea to adapt and change, but this change should be based on research and careful examination. Unfortunately, there has been very little research in the Saudi context, making it hard to base change on fact and difficult for Saudis interested in change to find evidence to support their arguments.

Nursing in Saudi Arabia is predominantly supervised by the medical profession and its regulations hinder Saudi nurses from being involved in decision-making processes (Altallal, 2006). This creates a relationship of dependence, due to which Saudis are not able to develop according to their cultural identities. The paradox here is that 'the true key to successful change is employee involvement and commitment' (Harvey & Brown, 2001, p. 4). Compounding this problem, the SNC is limited in its powers. It is not able to act effectively in its aim of establishing the Saudi nursing organisation as the exclusive nursing regulatory body, and is therefore

unable to reform the system and truly be accountable to Saudi nurses. This is evidenced by a lack of noticeable changes over the last 20 years.

Tumulty (2001a) conducted an evaluation of the existing nursing system at the MOH. At a regional level, she examined the nursing profession within all hospital levels and described the functional interrelationships of nursing within the MOH in Saudi Arabia. Tumulty (2001a) stressed that Saudi Arabia is a young country with an equally young nursing profession struggling to meet the needs of a growing population. The highest priority for the advancement of nursing in Saudi Arabia, according to Tumulty, was the creation of a kingdom-wide system of nurse regulation. Pressing needs include regulation of professional standards, the licencing of all nurses practicing in Saudi Arabia, accreditation of educational programmes and the formation of a national nurses' association. Consequently, among many recent developments in health care delivery in Saudi Arabia, much has changed, and is continuing to change, in the nursing profession. Further, much is changing in Saudi Arabia on a wider scale, including the noted employment of Saudi women (Miller-Rosser et al., 2006).

7.5.2 Environmental Barriers

A study of 12 Korean nurses working in USA hospitals conducted by Yi and Jezewski (2000) found that foreign nurses required 2–3 years to push through language issues and adjust to their new nursing environment. Omeri and Atkins (2002) conducted a study in Australia with five multinational nurses. They found that nurses experienced problems in adjusting to their new environment due to cultural, language and communication difficulties. In the study, multinational nurses described their experience as an 'unhappy' one (Omeri & Atkins, 2002, p. 503).

Environmental influences are all the external factors influencing the life and activities of Saudi nurses and other nurses within the context of their culture. However, as physicians' roles expand, nurses assume many roles formerly done only by doctors (Maas, 2006). According to Clancy and Abrams (2006), the health care workforce and the shortages of nurses have brought many challenges. Some of these challenges have moved from individual institutional issues to the legislative agenda and have implications for the profession and industry as a whole.

'Staff nurse work environments must be improved' (Schmalenberg & Kramer, 2008, p. 2).The American Association of Critical-Care Nurses (AACN) (2005, p. 189) proposed standards for establishing and sustaining healthy work environments. These standards are:

- Skilled Communication: nurses must be as proficient in communication skills as they are in clinical skills.

- True Collaboration: nurses must be relentless in pursuing and fostering true collaboration.

- Effective Decision Making: nurses must be valued and committed partners in making policy, directing and evaluating clinical care, and leading organisational operations.

- Appropriate Staffing: staffing must ensure the effective match between patient needs and nurse competencies.

- Meaningful Recognition: nurses must be recognised and must recognise others for the value each brings to the work of the organisation.

- Authentic Leadership: nurse Leaders must fully embrace the imperative of a healthy work environment (AACN, 2005, p. 189).

According to Heath (2002, p. 81), it is clear that nurses will not continue to work in environments that take little account of their professional and personal needs

and aspirations. These needs are many. Al-Ahmadi (2002) found, for example, that the most important determinants of Saudi nurses' job satisfaction were recognition, technical aspects of supervision, work conditions, utilisation of skills, pay and job advancement.

Research on why nurses are leaving full-time employment suggests that unless the working environment meets nurses' needs, nurses will choose either to move to casual employment or leave nursing. Nurses today have a range of skills in high demand in the labour market and, combined with higher levels of education, they are in an excellent position to choose from a range of other career options (McNeely, 1996; Norris, 2005).

When nurses face difficult external conditions, such as family obligations, their job satisfaction, professional identity and performance all suffer. A study carried out by Takase, Maude and Manias (2005) examines how the relationship between nurses' perceptions of their environment and their work values explain their job performance and the influence of this on job retention. The results revealed that nurses' job performance was continuing in an environment in which they received, despite their professionalism, few professional incentives. In contrast, negative environmental characteristics directly impacted on nurses' intentions to quit their jobs. Job motivation, work demands and professional development are the responsibility of the organisation (Bègat, Ellefsen & Severinsson, 2005).

This thesis has presented the numerous and complicated issues faced by Saudi nurses. However, these problems can be resolved. The process of Saudisation provides insight into the positive changes that can be implemented.

7.5.3 Saudisation in the Context of Nursing

It has long been argued in the nursing literature that Saudi Arabia will not and cannot continue its dependency on an expatriate health workforce (Searle and Gallagher, 1983). Nearly 30 years later, very little has changed given that the ratio of Saudis to non-Saudis has barely altered. Non-Saudi health professionals come with different cultural values and, for this reason, are not as effective as Saudis would be in implementing and promoting preventative and healing aspects of primary health care in the community (El-Sanabary, 1993; Mufti, 2000). There is no doubt that a continuing reliance on expatriate nurses poses financial, cultural and clinical problems and that having more Saudi nurses is highly desirable (Doumato, 1999; Mufti, 2000).

In 1995, a royal decree was issued by the Saudi government to promote the Saudisation of the nursing workforce to replace the mostly expatriate workforce and their escalating salaries (Mufti, 2000, pp. 6–7). The decree demanded that current expatriate workers be replaced by Saudi nationals. Health care is one of the largest sectors within Saudi Arabia targeted for Saudisation, with the Saudi MOH now concentrating on recruitment efforts for its largest group of workers—nurses (Brown & Busman, 2003; Miller-Rosser et al., 2006). To prepare Saudi nurses to fill roles otherwise performed by expatriates, Saudi nationals need to be trained and educated in all areas of employment. Further, with expatriates leaving the country because of Saudisation and other issues, there has been an increased participation of Saudi women in the workforce (Littlewood & Yousuf, 2000; Miller-Rosser et al., 2006). Indeed, remarkable progress has been made in raising the number of Saudi health providers, but this is often not recognised due to the continuing reliance on foreign manpower. According to Brown and Busman (2003, p. 347):

'This reliance on foreign workers can be problematic for the health

care sector, from recruitment and retention to more fundamental

issues in service delivery that may result from differences in

culture, language and professional skills.'

Moreover, although there has been an increase in the number of Saudi nurses trained, frequently they do not remain in the workforce. Therefore, the balance of active Saudi and non-Saudi nurses remains unchanged.

In the past, the expansion in health care facilities and services by the MOH, other government agencies and private sectors placed significant pressure on health planners to deal with a severe shortage of a wide range of health care workers, especially nurses. To meet the shortage, the only solution was to recruit nurses from overseas. It is claimed that, despite the announcement of the policy of Saudisation and the government's efforts in trying to satisfy the high demand for nurses with nationals, private sector employers have not cut back on recruitment of foreign manpower. One reason for this difficulty in implementing Saudisation lies in the fact that the cost of employing a Saudi nurse is equivalent to the cost of employing three nurses from South East Asia (Byrne, 2007). Consequently, many hospitals still prefer to employ expatriates. Further, the education level of expatriates is often higher than that of Saudi nurses.

Searle and Gallagher (1983, p. 659) examined Saudi health care accomplishments both for their intrinsic significance and as a means of examining the question of whether there is a 'single best' workforce strategy for developing countries. In considering the debates about appropriate workforce policies, they referred to the optimal strategy suggested by the WHO, who advocate the promotion of primary health care. Searle and Gallagher (1983) argue that the primary health care model is not the most appropriate for Saudi Arabia and countries like it. They

emphasise that the developing world is not monolithic, but contains within it enormous heterogeneity and diversity. Therefore, the authors claim that pluralism ought to be the principle guiding the evolution of health care systems in developing countries.

According to Mufti (2000), Saudis cannot ignore the implications of having mostly non-Saudi nurses at the first level of contact with the community. Non-Saudi nurses tend to stay in the country only briefly and, while expatriates dominate managerial positions, it is estimated that non-Saudi nurses in managerial and supervisory positions comprise less than 20 per cent of all expatriate nurses in KSA.

The MOH has already started to develop its own Saudi health workforce in all fields of health care in parallel to the development of a network of health services planned to cover all parts of the growing Kingdom. However, one reason Saudisation is slow is because most of the activities in health centres involve community contributions. Therefore, this expansion requires sensitivity to the unique customs and habits of the Saudi population.

El-Sanabary (1993) points out that the goal of Saudisation is not just a matter of national pride, but one of practical necessity. The imbalance in the nursing programme and intersectional distributing of Saudi health has been seen as a problem that requires urgent attention. Mufti (2000, p. 41) listed the objectives of the Sixth Development Plan (1995–2000) as:

- Replace expatriates by appropriately qualified Saudis in a gradual progressive manner;

- Provide job opportunities for all Saudi new entrants to the labour market, mainly in the private sector, and;

- Increase job opportunities for women in conformity with Islamic Shari'ah.

The Saudisation target is for the nurse to population ratio to be one nurse per 300 residents by the year 2025, with 25 per cent of nursing staff to be assistant nurses as shown in Table 7.4. According to Mufti (2000, p. 41), changing the ratios accelerates Saudisation.

Table 7.4

Saudisation in Nursing Percentages, 2000–2025

Year	Nurse to total population ratio		
	1/300 (Current) %	1/400 %	1/500 %
2000	21	28	35
2005	27	36	45
2010	33	44	55
2015	38	51	64
2020	44	59	73
2025	50	66	83

Source: Mufti, 2000, p. 41.

Table 7.4 shows the percentage of Saudis in the nursing workforce each five years for the current nurse to population ratio of 1:300, and for other, lesser ratios. By moving away from the current ratio of nurses (Saudi and non-Saudi) to the total population of Saudi Arabia to a lower ratio, Saudisation will increase more quickly, because fewer nurses will be employed, which means less expatriates. Of course, the main aim of Saudisation is more Saudi nurses as a percentage of the workforce. So, rather than focus on decreasing the ratio of nurses to population, it will clearly be better to increase the number of Saudi nurses.

Existing nursing programmes plan to increase the annual output of 3,858 nurses (Mufti, 2000, p. 40). At present, approaches to achieving Saudisation appear to present difficulties for the stability of Saudi nurses within their profession (Abu-Zinadah, 2008). The Vice Minister for Planning and Development at the MOH

announced on October 2007 that the Kingdom suffers from an excess number of

Saudi male nurses and at the same time a shortage of Saudi female nurses (Shalhoub,

2007). Perhaps more than anything this reflects a need for female nurses over males,

but it is a matter that can be clarified by further investigation in related research.

7.5.4 Recruitment and Retention

The idea that Saudi nurses need to be active in their profession was proposed

by expatriates who spent time working in the nursing profession in Saudi Arabia. For

instance, Phillips (1989) claims that Saudi nurses are in great demand because they

speak Arabic and are aware of local conditions and sensitive to the Saudi citizen's

needs and concerns. However, this is not supported by the employment patterns in

hospitals (Al-Ahmadi, 2002).

Economic factors also affect the expatriate mix within hospitals. MOH

hospitals are not able to attract nurses considered to be of high quality from

developed countries such as Australia and Canada (Byrne, 2007) because wages are

too low. Given the disparate levels of nursing education between first world and

developing countries, there is a significant variation of clinical skills and competency

(Byrne, 2007). Nurses with different skills need to be rewarded accordingly.

Retention in employment is a significant problem. From the 1980s, nursing

researchers reported that nursing was facing international recruitment and retention

difficulties (Roberts, 1983; Walter, Glass & Davis, 2001). Fifty precent of Saudis

who graduate as nurses leave the profession due to social and professional issues

(Abu-Zinadah, 2006). The shortage of Saudi nurses in general may not be an

indication that Saudis do not want to be nurses. There are Saudi nurses who cannot

find employment and others who have difficulty in performing the nursing duties.

Therefore, it would be beneficial to investigate issues relating to the processes of

education, preparation, clinical practice, management and career opportunities for professional nursing groups.

Walter et al. (2001) and Oweis (2005) argue that nursing continues to struggle for professional recognition and that it is important for nurses, both collectively and individually, to realise their significance and fight for their profession if retention is to be resolved. If professional status and care standards are to be improved, an informed dialogue to shape a more positive image of nursing as a profession is required. This necessitates promoting approaches to improve perceptions to bring about satisfactory reform within the nursing profession.

The reason behind the introduction of degree programmes in the United Kingdom (UK) was to increase interest in nursing (Robinson, Murrells & Clinton, 2006). Further, it was claimed that increasing the education of nurses would be one of the means of enhancing the process of professionalisation (Keogh, 1997). The providers of nursing education in Saudi Arabia were encouraged by government programmes to increase recruitment through enhancing education levels (Abu-Zinadah, 2006; MOH, 2008; Tumulty, 2001a). Recent figures indicate that recruitment in fact improved, and that total nursing education recruitment increased due to the growth in degree courses (Abu-Zinadah, 2006; MOH, 2008). However, it has been argued that Saudi nurse shortages are mainly a matter of retention in employment after graduation.

As around 50 per cent of the Saudi graduated nurses will likely leave the profession due to social and professional issues (Abu-Zinadah, 2006), the problems are ongoing. Abu-Zinadah, in 2006, predicted that, even with enrolment increases, Saudi Arabia needs 25 years to be able to train enough Saudi nurses so that they comprise 30 per cent of the Kingdom's nursing workforce requirements (Aldossary, While & Barriball, 2008).

The Saudi government has made improvements to nursing education, with an emphasis on the private health sector needing to participate. However, increased financial reward and more flexibility in working hours for female nurses are just some of the factors needed to improve job satisfaction and therefore retention in nursing. This is because nursing practice in Saudi Arabia has been significantly influenced by traditional, socio-political and cultural factors, which affect the nurses' view of their profession, as indicated by this research.

The lack of communication and research within managerial environments and the lack of support from society means that improvements in Saudi nursing have been slow to come. One area in which this is evident is in the language and knowledge used in nursing programmes and practice, both of which have been shown to be inadequate for the reality of nursing in Saudi Arabia. This lack of progress is indicative of the lack of research in this area, the lack of nursing programmes used in education and the problems involving the use of a particular language in policy and procedures and decision-making and other areas of communication. All these factors represent problems in nursing management. These are the things that make the recruitment and retention of Saudi nurses complex.

Retention of highly skilled professional nurses for the workforce is the key factor in ensuring a sustainable nursing workforce for the future (Heath, 2001). However, this need not involve new strategies. A number of non-Saudi studies have examined the various aspects of nurse education and training that have made it difficult to retain nurses and have advised on retention strategies (Aitken et al., 2001; Karmel & Li, 2002; Pearson, Nay, Koch, Ward, Andrews & Tucker, 2002; Pearson et al., 2002; Shah & Burke, 2001). Most of these studies indicate poor working conditions as the main reason nurses leave nursing practice. Aspects of poor working conditions cited include:

- Lack of recognition of nurses' skills and knowledge;

- Lack of nurses' competence to function as a professional;

- Lack of autonomy;

- Lack of career opportunities;

- Poor working conditions and safety;

- Shift work;

- Low pay compared to other professions;

- Stress; and

- Lack of child care facilities.

There is a critical shortage of qualified native Saudi nurses. Further, many certified Saudi nurses lack the skills necessary to be competent nurses. They have usually been deprived the most basic features of good nursing training, such as educational materials and practical activities (Tumulty, 2001a). Indeed, their lack of appropriate qualifications prevents them from being able to access the full range of job opportunities for nursing professionals. In Saudi Arabia, the nursing administration often explains reform in terms of providing opportunities to non-Saudi nurses to hold positions of responsibility in nursing practice, management and education. Therefore, nursing practices generally rely on multicultural approaches to nursing services, with a lack of involvement of Saudi nurses.

7.6 Lack of Empowerment

7.6.1 Working Conditions: The Demand for Sustainability

A greater nurse to patient ratio is one example of what is needed in Saudi nursing if nurses are to be empowered to work efficiently and with a sense of job satisfaction that will keep them in their profession. When the nurse/patient ratio is

greater, nurses have more time for providing care. This means they can better assess and care for their patients. When the ratio is less, nurses are rushed and often too busy to do more than provide minimum care. The number of nursing staff in a centre has a significant negative effect on morbidity and mortality, including failure to rescue (Aiken, Clarke & Sloane, 2002a; Needleman, Buerhaus, Mattke, Stewart & Zelevinsky, 2002; Stone, Mooney-Kane & Larson, 2007). Kane and Shamliyan (2007) indicate a consistent relationship between number of nursing staff and patient outcomes. They show some occurrences of specific adverse events linking nurse staffing to patient outcomes, especially in critical care. Higher staffing levels are associated with lower mortality (Aiken, Clarke, Sloane, Sochalski & Silber, 2002b) as well as a lower incidence of infections and postoperative pulmonary implications such as septicaemia (Stone et al., 2007). These are associated with the amount of financial resourcing and commitment in nursing management (Aiken et al., 2002a). In view of this, Saudi Arabia needs more funding for nursing—both in training and in creating a more suitable nursing environment conducive to effective nursing (Tumulty, 2001a). Higher staff to patient ratios also provide greater job satisfaction for nurses. This is an important prerequisite if a greater retention of Saudi nurses is to be achieved.

An improved nursing management is one way to support nurses in solving their practical issues and maintaining their work environment. A positive work environment is realised when nurses feel that management is positively influencing their sense of wellbeing. Previous research shows that the most acceptable psychosocial work environment is the positive work environment that is linked to social factors and individual behaviour and thought (Begat & Severinsson, 2006; Begat 2006). Begat and Severinsson (2006) found a strong correlation between the suitability of an environment and nurse satisfaction.

7.6.2 Professional Identity and Saudi Nurses

The research findings indicate that professional identity is a problem for Saudi nurses. As many scholars who study professions have noted, 'one of the characteristics that distinguishes the professions from other occupations is that their members are expected to develop professional identities' (Costello, 2005, p. 17). It is important to examine nurses as people and as professionals. By understanding how Saudi nurses view themselves and their profession, an identity baseline can be established. Even if low, it can improve with the appropriate education and management.

Different approaches have been used to measure and understand nurses' professional identity (Fagerberg & Kihlgren, 2000; Gregg & Magilvy, 2001; Hallam, 2000; Ohlen & Segesten, 1998). According to Burke and Stets (2009) identity theory involves what it means to be who we are. They define identity as:

> 'The set of meanings that define who one is when one is an
>
> occupant of a particular role in society, a member of a particular
>
> group, or claims particular characteristics that identify him or her
>
> as a unique person' (Burke & Stets, 2009, p. 3).

The identity of a particular professional group, including that of nurses, is very much influenced by who the individuals are when outside of the group. This means that to understand the professional identity of nurses, researchers need to consider the cultural and religious backgrounds of nurses as well as the context in which nurses learn and work. When nurses describe something as being decent, moral or something that they like or dislike, these are personal characteristics that identify them as unique persons. According to Burke and Stets (2009), people possess multiple identities because they occupy multiple roles, are members of

multiple groups and claim multiple personal characteristics. It is no different for nurses.

Identity is not just a feeling, a value or an understanding that nurses have. Nurses experience the meaning of their identity as being a nurse when they interpret what it means to act; that is, practice (Burke & Stets, 2009; Fagerberg & Kihlgren, 2000). It is the practice of nurses that give them their identity as a group and these actions are linked to social structures in nursing (Burke & Stets, 2009) as well as outside of nursing. Therefore, professional identity involves the interactions of nurses, with nursing identity often being guided by collective beliefs and values, which all nurses hold (Fagerberg & Kihlgren, 2000; Gregg & Magilvy, 2001). Values and attitudes describe the cultural characteristics of a specific group (Phinney, 1996). For example, Saudi nurses have meanings that they apply to themselves in regard to being Muslim. When a Saudi nurse practices caring from an Islamic point of view, he or she will represent the reality of being a Muslim.

The professional identity of nurses has been explored in other cultures. Gregg and Magilvy (2001, p. 47) have explored the process of establishing the professional identity of Japanese nurses. Gregg and Magilvy (2001, p. 47) identify six categories of how individual nurses establish their professional identity. These are:

- Learning from working experiences;

- Recognising the value of nursing;

- Establishing one's own philosophy of nursing;

- Gaining influence from education;

- Having a commitment to nursing; and

- Integrating a nursing into self.

Burke and Stets (2009, p. 3) point out that:

'Identity theory seeks to explain the specific meanings that

individuals have for the multiple identities they claim; how these

identities relate to one another for any one person; how their

identities influence their behaviour, thoughts, and feelings or

emotions; and how their identities tie them into society at large.'

There needs to be a greater examination of what nurses think and of how they

feel. In the words of Johns (2005, p. 1):

'In order for nurses to assist others through the process of

expanding consciousness, they need to be aware of their own need

to work at differing levels of consciousness.'

A nursing professional's identity involves ideologies about caring (Gregg and

Magilvy, 2001; Kahn and Steeves, 1988). Cooley (1902), as cited in Burke and Stets

(2009, p. 3) claims 'the individual and society are two sides of the same coin'.

Identities characterise individuals according to their many positions in society and

the individual and society are linked in the concept of identity (Burke & Stets, 2009).

This means that the professional identity of nurses in Saudi Arabia cannot be

separated from who they are as people and, in this context, their religion as well.

Bowling (2002, p. 19) says scientists:

'Argue that … reality is socially constructed through the

interaction of individuals and their interpretations of events; thus

the investigator must understand individuals' interpretations and

experiences.'

Professional identity is affected by who we are, how we feel, where we come

from, how we are treated and what our work environment is like. In relation to the

Saudi nurses, the Saudi culture is mainly based on the religion of Islam (the singular

authority in Saudi society). A Saudi nurse's identity of being a nurse involves being

a Muslim. Saudi Arabian nursing identity comprises the varied experiences of nurses

in many different situations. This thesis is about the Saudi nursing experience, but it

cannot be forgotten that Saudis and expatriates work together in the same system and

they share the same professional identity.

It is argued in this research that nursing in Saudi Arabia, traditionally and

currently, has struggled with its identity. It is important therefore to explore,

understand and interpret the meaning that nurses give to their existence as Saudi

nurses. This relates to their experiences within their culture, especially in the current

nursing climate in Saudi Arabia in which, as Walker (2005) maintains, the profession

struggles to recruit and retain its workforce. Indeed, a profession that struggles with

its sense of identity will find it difficult to recruit and retain a workforce. However, a

profession that experiences satisfaction in what it is and what it does will attract and

maintain an exciting workforce (Walker, 2005).

7.7 Paradox of Communication: Communication Barriers

In any health care system 'communication and collaboration among health

care professionals is critical to delivering high quality and safe patient care' (AACN,

2008, p. 4). From a phenomenological standpoint, the language that we speak affects

how we think about the world in which we live. In view of this, nurses who speak

English as their native language are at an advantage in nursing because nursing

expresses itself in English; everything is written in English in Saudi Arabia, from

textbooks and manuals to labels on medicines.

'Nurses must be as proficient in communication skills as they are in clinical

skills' (AACN, 2005, p. 190). Many Saudi nurses, even those in leadership positions,

have a poor knowledge of English (Al-Hosis, 2010; Tumulty, 2001b). As a result, Saudi nurses lack the appropriate communication skills and find it difficult to relate to expatriate nurses. Saudi nurses are not proficient in English and they struggle to carry out their duties and improve their learning. Communication is what we do to understand. This understanding leads to meaningful principles being established. Communication in specific languages is a much broader concept, involving mainly the process of transmission and reception of all kinds of information (Harvey & Brown, 2001; Jagtenberg & D'alton, 1989). This process of communication is considered as 'a causal factor for anything and everything that is done improperly in an organization' (Milton, Entrekin & Stening, 1984, p. 344).

For educational purposes, verbal communication is considered to be fundamental for organisational development (Crystal, 2008; Knowles, 1990; Milton, Entrekin & Stening, 1984; Pinker, 2008) and phenomenologists consider this to be important for understanding the intentional meaning of cultural concepts (Husserl, 1970; van Manen, 2000). According to Knowles (1990), there is a behavioural side to communication that emphasises the meaning of the intended message in the communication process. The intended meaning can be referred to (Husserl, 1948) as the, needs, attitudes, values, and perceptions of the sender … [as they are] … reflected in the message' (Milton, Entrekin & Stening, 1984, p. 345).

For Saudi nurses, the language used for communication is not clear to them. Given this, the ability of the Saudi nurses to help, support and provide care to Saudi patients and their family members is at risk. Even if the skills of expatriate nurses were exceptional, this would not absolve the Saudi nursing authorities from responsibility for the cultural, social and psychological wellbeing of Saudi nurses and patients (Al-Ahmadi, 2010). Further, there is very little communication between Saudi nurses and nursing management and this is an issue for nurses. So too are

communication issues relating to understanding medical and nursing discourses. However, despite these difficulties, Saudi nurses understand their patients.

Brady and Arabi (2005) point out that the language barrier is an obstacle for optimal communication between the patients, family members and the non-Arabic-speaking health care professional. Misinterpretation, confusion and conflict may occur among nurses and between nurses and patients. Given that most of the nurses working in the government hospitals are non-Arabic-speaking (Luna, 1998), the Saudi patients' needs are often misunderstood (Al-Shahri, 2002). Their needs often involve understanding their culture and so they are best met by Saudi nurses. According to Brady and Arabi (2005), there are implications for the patient and the family when health care is delivered by a multicultural team. Interpreters are frequently needed to facilitate communication between English-speaking staff members and Arabic-speaking patients (Al-Shahri, 2002) and this is not always an efficient process. Saudi nurses are too often interpreting for expatriate nurses and because of their lack of English skills (as well as in the other languages of expatriates), this raises problems. Saudi nurses used as interpreters would give their own interpretation of the information as they translate and this may be inaccurate (Brady & Arabi, 2005). Likewise, problems occur when information given by non-Arabic professionals is not translated correctly by the Saudi nurses or others. The situation of communication in nursing is compounded further with Asian nurses, for example, who use English as their second language.

It has been argued that inadequate communication and lack of cooperation and conflict resolution techniques continues to disempower nurses and obstruct improvement of workforce conditions (Latham, Hogan & Ringl, 2008). The interactions between Saudi nurses and expatriates impact on the clarity of communication. This affects the course of action in relation to decision making

(Altallal, 2006). Brady and Arabi (2005, p. 545) claim that, 'the effectiveness of non-Saudi, often non-Arabic-speaking health personnel [is] limited by their inadequate understanding of the Saudi environment and culture'. According to Nyrop (1984), as cited in El-Sanabary (1993, p. 1339), 'patient communication has suffered because of the cultural gulf'. Brady and Arabi (2005, p. 546) stress that 'because of the problems in communication, accurate information, comfort and support, and negative emotions may arise within patients, their relatives, and healthcare workers'.

The language barrier extends into everyday communication. It also involves the delivery of speech in relation to tone of voice and non-verbal communication such as facial expressions, hand gestures and overall manner (Brady & Arabi, 2005; Crystal, 2008; Pinker, 2008). In this environment, misunderstandings can occur resulting in negative emotions such as frustration and feeling offended, which can lead to low individual morale and affect overall teamwork and performance (Brady & Arabi, 2005).

Maas (2006) points out that nurses are assuming greater responsibility in the management of acutely ill patients in hospitals, as well as greater responsibility for each other. For nurses to meet complex health care challenges, Maas (2006, p. 13) argues that hospital staff nurses require expert clinical and communication skills to do the following:

- Provide evidenced-based care;

- Use information systems to manage patient care;

- Provide culturally sensitive care within a holistic framework;

- Maintain the 'human caring' component of patient care;

- Counsel patients' families;

- Focus on the system level while providing direct care;

- Interface and collaborate with other health care providers;

- Keep up with rapid technological advances while adapting to change and

  chaos; and

- Participate in clinical research (Maas, 2006, 13).

These tasks are obviously very difficult to carry out in an environment in which there are communication barriers. Nursing authorities in Saudi Arabia need to acknowledge this, as well as acknowledge that 'communication is only a part of good management (Milton, Entrekin & Stening, 1984, p. 344).

7.8 Paradox of Education

7.8.1 Inadequacies in the Education System

The recruitment and retention of Saudi nurses also depends heavily on educational practices and management within the nursing profession. Although educational and training courses continue to improve in Saudi Arabia, these improvements are limited, principally by the lack of suitably qualified nursing instructors.

For Saudi nurses, the development of their profession is as important as nursing values. Kossman (2009) claims the values of responsibility, integrity and professionalism reflect values in higher education. This connection between personal and professional values helps nurses manage their goal of becoming fully satisfied nurses. Further nursing education and training provides nurses with an assortment of strategies to expand their horizons and enrich their clinical practices (Oermann & Heinrich, 2007; Pharris, 2009). Strategies for continuous quality improvement in nursing education need to focus on teaching cultural competence and skills to manage the difficulties nurses come across in different practical settings (Pharris, 2009). Nursing education in Saudi Arabia needs not only to teach nursing in English,

but should also search for an ethics-sensitive language and an epistemology of practice that is guided by a relational sphere between teachers and students (van Manen, 2000a).

Saudi nurses need to be well-prepared if they are to provide effective care for patients. This preparation is best achieved through more emphasis on education at undergraduate and post-registration levels. Lack of preparation leads to creation of barriers to students' education and increases their sense of isolation and struggle (Kossman, 2009). Clinical practice also needs to be monitored and any dangerous practices highlighted. Further, nurses need to be supported through in-service training for them to practise safely. If these strategies are implemented, nurses will feel more confident in their skills and ability to care for patients (Kossman, 2009).

Extra responsibilities undertaken need to be rewarded with commensurate salary. Extra allowances or penalty rates for night duties would act as some incentive (Tumulty, 2001a). Another salary area requiring change is the recognition of responsibility; extra allowances would motivate Saudi nurses to work towards positions such as charge nurse, head nurse, nursing supervisor and nursing director.

As mentioned earlier, the opportunity to continue nursing studies should also be given. Consideration of shift times and time given to be with families would make the nursing position more appealing. Rotation of wards for experience and mentoring programmes to build confidence would also be beneficial (Tumulty, 2001b). Both monetary rewards and non-monetary rewards are important in building job satisfaction. To feel valued for providing an essential service is of utmost importance.

7.8.2 Professional Assessment

A competency can be described as an attribute of a person that results in effective performance (Jeffreys, 2006). This includes skills, attitudes and other characteristics attained by nurses, based on knowledge and experience, which together are considered sufficient to enable nurses to practice as professionals (Aloen & Townsend, 2008; Jeffreys, 2006; Krentzman, Leininger, 2002). The Professional Practice Standards suggest a combination of skills, knowledge, values, attitudes and facilities to strengthen efficient performance in professional practice. The standards provide professional services and act as a point of reference against which performance can be assessed (Pearson, Fitzgerald, Walsh & Borbasi, 2002; Watson, Stimpson, Topping & Porock, 2002). Many Western countries require competency-based education and practice. Competency-based education provides a minimum standard that many Saudi nurses are currently unable to meet.

The delivery of the best possible health outcomes depends on both the competence of the nurses providing the professional service and the quality of the system through which nurses deliver that service. Recent research conducted in Western countries has emphasised the need for standardisation of clinical practice and the assessment of performance. It is suggested that standardisation would diminish or at least moderate the variation in the quality of care and ultimately benefit the patient through continuity of care, cost control and best practice (Parker & Lawton, 2000).

Although some researchers have focused exclusively on nurses, exploring cultural effectiveness or cultural competency in delivering care (Dozier, 1998; Jeffreys, 2006; Krentzman, Aloen & Townsend, 2008; Leininger, 2002; Luna, 1998; MacDonald, 1989; Napholz, 1999), very little is known about the issues and the performance of Saudi nurses. The varied cultural backgrounds and experiences of

health care professionals may further confound problems regarding professional

practice (Brown & Busman, 2003). The need to reduce health care costs and recent

disclosures on incidences of clinical error have resulted in rising alarm in Western

industrialised countries about the accountability and performance of health care

professionals (Parker & Lawton, 2000). Pearson et al. (2002) claim that nursing

performance can be recognised by competency-based assessment and that there is

wide recognition of the use of competency assessment as a valued tool. Continued

regulation of competence in nursing practice needs to be undertaken with a suitable

intensity in a wide range of situations (Pearson, Fitzgerald, Walsh & Borbasi, 2002).

Hudak, Gallo and Morton (1998) point out that holistic nursing care involves

providing nursing care while keeping the totality of the patient in mind. Following

from this, Cowan, Norman and Coopamah (2007) claim that an integrated holistic

approach to measure competency is extensively accepted. The Australian Nursing

Council (ANC) (2002) identified a number of important principles for the

assessment of National Competency Standards (NCS) for registered and enrolled

nurses. With the introduction of the NCS (2000), the ANC has shifted to an

emphasis on assessment of total performance, a holistic approach that includes

knowledge, skills and attributes.

The NCS is considered by the Australian nurse regulatory authorities to be

important to ensure initial and continuing competence (ANC, 2000, p. 1). The term

'competence' is defined by the ANC as 'a combination of skills, knowledge

attitudes, values, and abilities that underpin effective performance in a

professional/occupational area', while 'competency' is defined as 'an attribute of a

person which results in effective performance' (ANC, 2002, p. 6). Nursing curricula

are approved only if the programme aims for these standards to be met by the end of

the course.

The ANC (2000) has placed emphasis on the accountability of the evaluator or 'assessor'. This assessor, belonging to an appropriate regulatory authority, must be able to make a valid and reliable assessment about a nurse candidate's performance. The ANC also emphasises that the nurse applicant be assessed according to the competency standards required (ANC, 2000). An 'assessor' is defined by the ANC (2000, p. 6) as:

> 'A person who is educated in assessment of performance, is experienced in the nursing performance being observed and has demonstrated skills in analysis, interpretation and evaluation of elements of the assessment process.'

Competency standards recognise the relationship that exists between the nurses, the patients and their families, their social group and the values of the customs and beliefs of all individuals and groups (Chiarella, 2006; Hudak, Gallo & Morton, 1998; McMurray, 2004). However, no such standards are required in Saudi Arabia. The integrated holistic approach appropriate to deliver culturally competent nursing care is a social interaction, involving all individuals and groups in our society. A respect of culture, values and beliefs of individuals is important (Hudak, Gallo & Morton, 1998; McMurray, 2004). With competency, the impression of validity and reliability in the assessment process requires that the assessors regularly meet and affirm principles to bring about the intended outcomes (ANC, 2000; Mores, 1994). The responsibility of the regulatory authorities becomes essential in relation to the organisation, nurses, public interest and safe environment for practice (ANC, 2000).

This research has explored Saudi nurses' issues regarding competency standards and professional assessment in Saudi Arabia. Findings from this research

reveal that professional assessment is lacking and that this is definitely one area of Saudi nursing that needs to change.

7.9 The Need to Empower Saudi Nurses

Al-Aameri (2000) examined the level of job satisfaction and organisational commitment for nurses in Saudi Arabia, particularly in public hospitals in Riyadh. Three hundred and sixty-six nurses from different nationalities responded to Al-Aameri's research. He found that nurses in public hospitals were only slightly satisfied and committed to their hospitals. The results of his research showed the most important determinants of job satisfaction included recognition, technical aspects of supervision, work conditions, utilisation of skills, pay and job advancement. Also, his findings show that more experienced nurses are more committed to their organisations and that satisfied nurses tend to have a higher degree of commitment than less satisfied ones. Dissatisfied nurses tend to have a low degree of loyalty. This corresponds to the findings of other researchers, who have found that satisfied employees are more productive and committed to their jobs, whereas dissatisfied ones experience absenteeism, stress, grievance and turnover (Al-Hosis, 2006; Burke, 2000; Hajbaghery & Salsali, 2005).

Raub and Robert (2010) have explored the relationship between psychological empowerment and extra-role behaviours and found that increases in responsibility given to employees indicates a greater sense of empowerment. Empowered nurses are highly motivated and are competent in motivating, inspiring and empowering others by sharing the sources of power (Laschinger & Havens, 1996; Speedy & Jackson, 2004).

7.10 Achieving Empowerment

Empowerment is the strongest predictor of organisational productivity (Birdi et al. 2008). However, according to Blanchard, Carlos and Randolph (1999, p. 2), there is a problem with 'people's lack of understanding of how to move from a more traditional hierarchical mind-set to a mind-set of empowerment'.

There are four structural conditions identified by Kanter (1993) as being key contributors to empowerment. These are: opportunity for advancement and to be involved in activities beyond one's job description; access to information about all facets of the organisation; access to support for one's job responsibilities and decision making; and access to resources as needed by the member of staff. Manojlovich (2007) states that nurses' power may arise from three components: a workplace that has the necessary structures that promote empowerment; a psychological belief in one's ability to be empowered; and acknowledgement that there is power in the relationships and caring that nurses provide. Key words written by Kanter as cited in Manojlovich (2007, pp. 2–3) in relation to empowerment are: opportunity, advancement, involve[ment], access, information, support, decision making, resources, promotion, belief and acknowledgement. These words have all featured in this research in the statements of the nurses interviewed.

Blanchard et al. (1999) identify three keys to empowerment. The first key is information, which the authors say managers must share liberally with employees to help create a sense of ownership. Next is setting up understandable boundaries that will make employees feel both comfortable and challenged. Finally, managers must develop teams to replace the old hierarchical structure. Prepared with a new model of empowerment such as this, nursing organisations can perhaps find their way in the demanding world of universal competition. However, such thinking is only the beginning. What is needed is more research: research that tackles the issues revealed

in the lived experiences of nurses and explores the changes nurses think and believe are necessary for the betterment of Saudi nursing.

Adib-Hajbaghery, Salsali and Ahmadi (2004) conducted qualitative research with Iranian nurses that explored their understanding and experiences of professional power. They found nurses' power was influenced by 'application of knowledge and skills', 'having authority, 'being self-confident', 'unification and solidarity', 'being supported', and 'organizational culture and structure'. The authors perceive that nurses' power is dependent on obtaining and applying professional knowledge and skills in practice and there is no reason to believe the situation is different for Saudi nurses.

Saudi nurses cannot empower patients if they are not empowered. McLean (1995, p. 130) describes empowerment of patients as 'the personal and political processes patients go through to enhance and restore their sense of dignity and self-worth'. This describes exactly what nurses need, and what they must have if they are to be able to care for their patients adequately and assist their patients in finding empowerment.

7.11 Conclusion

It has been the aim of this research to explore the experience of being a Saudi nurse and explore the needs Saudi nurses have, based on their understandings of their development and practice as nurses. It has been revealed that continuing education for Saudi nurses is especially difficult in the face of language problems. Further, overall, Saudi nurses do not have a strong enough voice in nursing policy making and they lack power in their profession. Again, language problems contribute to this, compounded by the fact that they are a minority in their workforce.

What remains to be explored in this inquiry is the essence of the meaning that the participants intended to convey. It will be argued that Saudi society and Saudi nurses as professionals still struggle to understand the concept of caring from an Islamic standpoint.

Chapter 8: Discussion

8.1 Introduction

With less than 30 per cent of nurses working in KSA being Saudi, the lack of native Saudi nurses is a serious problem for the effective delivery of nursing services in that country. This situation appears to be unique to Saudi Arabia as a developed nation. This deficit of native nurses is a consequence of inadequate qualifications, a lack of defined career paths, lack of professional development and inadequate rewards for nurses. Consequently, there is a high attrition rate, with approximately 50 per cent of qualified nurses leaving the profession, and this has created a nursing workforce crisis. These issues have a direct impact on the health of the Saudi public, and affect health outcomes.

The findings show that native Saudis are less likely to choose to become nurses and, if already qualified as nurses, they are unlikely to cooperate with management or accept work assignments and may tend towards leaving nursing. By way of explanation for this phenomenon, findings from this research reveal a sociocultural paradigm that still culturally segregates being a nurse from being a Muslim. A lack of social support and the lack of professional commitment of nursing organisations, raises great concern.

From a phenomenological point of view, an individual's knowledge of their life-world and their knowledge of their own physical world is necessary for their understanding of the meaning of being-in-the-world (Husserl, 1913). For nurses, the phenomenological approach to this research encouraged them to explore meaning in their lives and within their lived experience as nurses. Husserl called the commonsense, straight forward world the '*Lebenswelt*' (the life-world) (Scruton, 2004, p. 245) and argued that straightforward experience, in which the life-world is

explored, 'is the ultimate foundation of all objective knowledge' (1945, p. 226). According to Gadamer (1975), the life-world is concerned only with things that we see daily before us, experiences that hold an entire society together. This research has brought to light the straightforward commonsense life-world experiences of Saudi nurses. It has questioned the way Saudi nurses experience their world and shown the characteristics of being-in-the-world as it is experienced.

In Husserl's concept of the life-world, he underlined the importance of our intimate engagement in experiential life and highlighted the view of how descriptions of lived experiences enhance our awareness (Husserl, 1970). For Husserl, this view counts as a starting point—in this case, for understanding the lived experience of nurses—which he claims is better than an explanation (Todres & Holloway, 2004, p. 81). Phenomenology as a method investigates intentional experience (as experienced) by analysing the structure of various forms of experiences (Husserl, 1913; Kupers, 2009; Smith, 2007). As stated earlier in the methodological review, phenomenology practiced from a human science perspective can result in valuable knowledge about individuals' experiences.

8.1.1 Structure of the Discussion

This chapter will discuss and make sense of the findings represented in the previous chapter. This involves an interpretation of the primary themes that have emerged and then an examination of the relationships between the themes. In addition, the interconnectedness of the themes will be explained. Finally, it will be demonstrated that two themes emerge as stronger and more pertinent than the others. These themes are the twin essences of the findings and will be examined in relation to nursing literature, Husserlian writings and Islamic cultural and religious viewpoints.

8.1.2 Themes and Issues

As this research progressed, themes were grouped according to Sociocultural Factors and Organisational Paradoxes. All the themes are intrinsically related, and stand together as a group of themes that can best be understood in their relationship to each other.

8.2 Interconnectedness of the Themes

8.2.1 Sociocultural Factors

These factors concern the thoughts, perceptions and misunderstandings of people. As shown in Figure 8.1, the sociocultural factors describe the influences of the attitude of the population towards nursing.
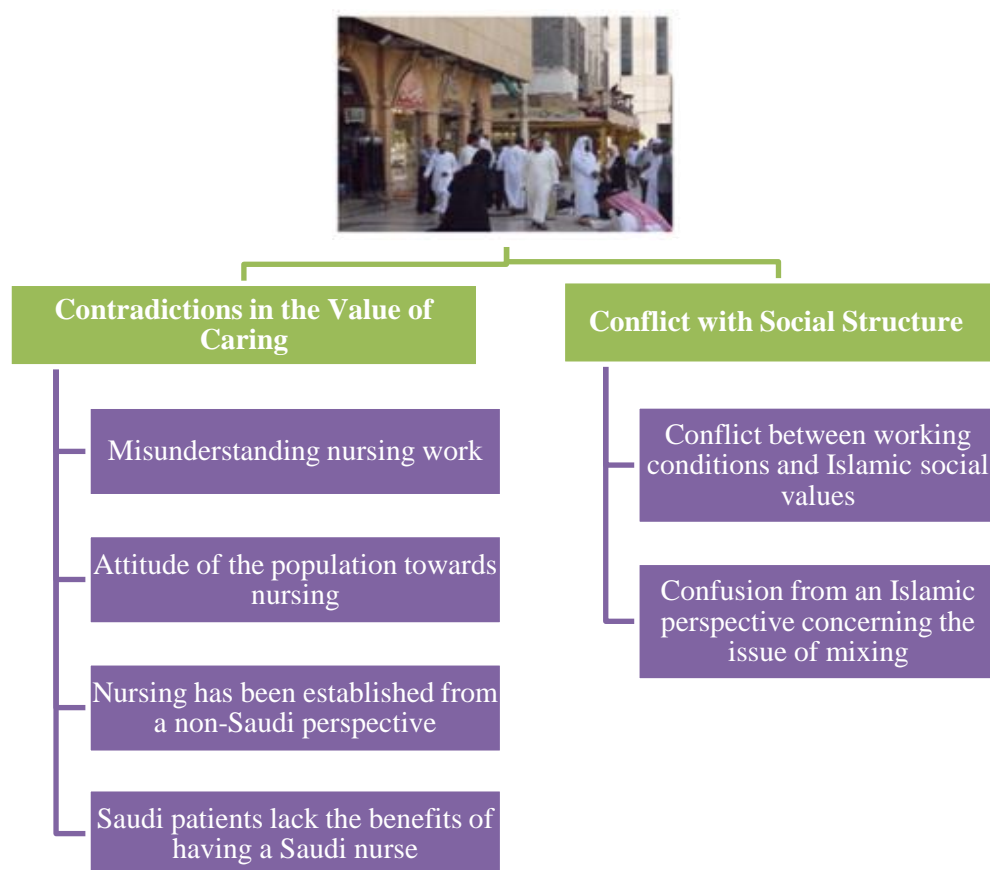
Figure 8.1. Classification of the sociocultural factors.

The research findings provide evidence that culture affects and reflects perceptions. The findings are consistent with the results of the recent phenomenological research of Nasrabadi and Emami (2006) in which nursing was examined from an institutional and sociocultural perspective to explore the relationship between cultural factors and nursing performance. Nasrabadi and Emami (2006) found sociocultural factors to have a significant impact on nurses and on cultural competence in the nursing profession. Al-Abdulwahab and Al-Gain (2003) also found that cultural values, such as traditional beliefs, educational environments and religion, are factors that strongly affect the attitudes of nurses.

In this research, many aspects of Saudi culture have been shown to influence Saudi nurses' perceptions, the way they perform their duties and the recruitment and

retention of Saudi nurses. In Norah's case, her traditional upbringing had a profound influence on her experiences as a graduate nurse. She explains:

> At the beginning, I was very shy and frightened because I did not believe that I would have the ability to work in nursing. Of course, I was closed in a family inside a house from which I could not get out due to traditions and customs … A daughter does not have to go out alone from the house and she cannot speak with a stranger. When I worked, I faced the public and the patients. It was hard to adapt to these situations because my life at home made me shy.

Since Saudi nurses, both male and female, interact with expatriate nurses from different cultures, the influence of more than one culture is often involved. Culture affects and reflects perspectives, beliefs, values, our relationships and the influences we have on each other. The ANA (1991) claims that knowledge of cultures and their impact on interactions with health care is essential for nurses.

In Saudi Arabia, culture is viewed as inseparable from the religion of Islam. To understand the sociocultural factors that influence Saudi nurses' needs and abilities, it is important to understand the influence of Islam on Saudi society and on nurses and their families in particular. It is this understanding that reveals the seeming contradiction between the job demands of being a nurse and the expectations Islam places on a faithful Muslim.

8.2.1.1 Contradictions in the Value of Caring

Nursing is meant to be a caring profession. Its origins lie in a desire to meet the needs of the sick and wounded; to help with healing as well as to provide comfort. Saudi nursing administration desires that nursing be a caring profession and nurses, generally, agree that nursing is about caring. Further, those who are attended

by nurses expect nursing to be a caring profession. However, in Saudi Arabia there are many barriers and obstacles to achieving this ideal. Poor working conditions, a lack of understanding of Saudi culture and nurses by expatriate nurses and a lack of training are just some of the factors that create a situation which makes the life of nurses difficult and contradicts the value of caring.

Under this category a number of themes were identified: misunderstanding nursing work, the attitude of the population towards nursing, that nursing has been established from a non-Saudi perspective and that Saudi patients lack the benefits of having a Saudi nurse. The Saudi public does not understand nursing. They do not understand the relevance and importance of nursing or how it is linked to being a Muslim. Instead of seeing the chronic shortages of Saudi nurses and the benefits of being cared for by a Saudi, they see Saudi nurses and they wonder about their families and their family life and they wonder if these nurses are really representing their religion appropriately. Imtinan outlines the problem:

> 'Still our community rejects the work of females as nurses. The problem is that the community does not know the real and true role of the nurse. I knew many Saudi girls willing to be a nurse but because the job of nursing involved mixing, therefore they could not enter the nursing profession. This matter affects female Saudi girls in choosing nursing as a career.'

Since Florence Nightingale's time, nursing has been understood as a profession for educated females. Nursing has continued to be a gendered profession. In Australia, for example, less than 10 per cent of registered nurses are male (Australian Institute of Health and Welfare, 2011). Consequently, any view that understands nursing in human terms—in which men and women are equal in a

profession such as nursing—rather than in gendered terms, is not understood adequately by Saudi society.

The participants in the research agreed that Saudi people need to understand the nature of the nursing which Saudi nurses provide and its relation to Islam. Faten reflects this view when she says:

> 'Especially in this city, the people did not really understand the
>
> role of the nurse. In their minds, to be a nurse is to be mixing with
>
> the other gender.'

Only when people understand nursing will the relationship between Saudi nursing and Islam be clearly understood. Nursing will then be accepted and people will respect the nurse's role. Once there is understanding, nursing will be seen as compatible with Islamic views about caring. Only then will Saudi society will be supportive of nursing and promote it as an honoured profession.

Society's attitude towards male and female nurses is not acceptable to Saudi nurses. Rufaida is just one nurse who explains this:

> 'When my friends asked me about my job … I tried to explain to
>
> them how good and pleasant such a noble profession is.'

Sarah comments on the low status of Saudi nurses:

> 'Some of my friends are nurses and they do not want to tell others
>
> in the community that they are nurses.'

Khalid shared this experience:

'The majority of the society in which we live looks to nursing as an

unfavourable job. Even after graduation no one dares say that I am

a nurse; we are ashamed of this.'

This prevailing attitude of society needs to be changed so that nurses receive

the respect and job conditions they deserve, which would allow them to practice their

caring profession as it needs to be practiced. Respect for nurses is necessary if we are

to keep Saudi nurses nursing and attract more Saudis to nursing. If Saudisation is to

proceed as planned, these issues must be addressed. This change would be best

promoted by rewarding nurses appropriately for their professional services. Further,

Saudi society needs to be educated—perhaps by a scheme that promotes nursing to

the public—to see the wonderful and necessary role Saudi nurses play in society.

A change in attitude cannot be achieved on a larger scale without the

government and nursing authorities working hard to change the attitude of the

population towards nursing. In addition to increased rewards for nursing and the

promotion of nursing, nursing education programmes need to be improved and made

more accessible. Another idea that could recast society's perception of Saudi nurses

is the running of a television campaign telling the story of the first Muslim nurse and

how the prophet blessed her actions. This would clearly demonstrate that nursing and

Islam are compatible. However, the most effective promotion of nursing is internal

to the profession; that is, making the necessary changes so that nurses are happier in

their profession. An integral aspect of this is the granting of more control in nursing

to the Saudi nurses themselves.

Nursing in Saudi Arabia in modern times is dominated by nurses and nursing

administration from the west. Sami states, 'Our society views nursing as a work of

foreign women'. Development of Saudi nursing must consider Islam. Khalid echoed

the views of many of the other participants, stating:

'There are many foreign nurses who are unable to understand

patients' customs, traditions and religious beliefs … a foreign

nurse will never be sufficient. Any nurse, whether male or female,

that doesn't become familiar with the customs, traditions and

religion of the country, will not be able to offer the necessary

nursing care … The Saudi patient (male or female) requires special

treatment that foreigners find difficult to understand.'

It is difficult to deny the ideal role of Saudi nurses. Huda said:

'Many foreign female nurses… don't know Arabic. Most patients

need someone who understands them and tries to help them

psychologically. The Saudi patients need someone who teaches

them and explains to them the nature of the service provided. Most

foreign nurses do not have sufficient ability to deal with the Saudi

patients.'

So far there has not been enough consideration of the importance of

increasing Saudi control over nursing and developing nursing according to the

requirements of the patients and the society. Instead, the nursing profession has

continued to rely on multinational approaches—the Saudi nurse's education, practice

and management are all based on different languages and resources—which broadly

ignore the inherited nature of the Saudi nurse's culture and the context of their

nursing. In fact, currently, Saudi nursing does not have a theoretical foundation, such

as a model of care. The need to create a Saudi model of the nursing profession that is

in line with the contemporary psychological and social culture of the Saudi people is

essential. However, this cannot happen without an understanding of nursing's

relationship to Islam.

The findings reveal that Saudi patients prefer Saudi nurses and this indicates that Saudi nurses are the most appropriate nurses to serve Saudi society. The narrative of the participants exposed the importance of Saudi nurses. They feel foreign nurses are unable to do the job properly and that foreign nurses lack cultural understanding as well as adequate knowledge of the Saudi language. Sami explains:

'There are no programmes and education courses for teaching the foreign nurse the Saudi traditions and customs … Saudi nurses know the Saudi culture and people in a way that the expatriate nurses do not.'

'Saudi nurses are better informed [than expatriates] about the nature of society, they speak the language and understand the condition of the patient. But our society has the idea that foreigners are better than Saudis' (Sarah).

The above statement indicates that Saudi nurses have a greater ability to manage Saudi patients. Knowing the culture of the patients is a critical component in nursing care. It is essential for nurses to be able to communicate effectively and to avoid cultural misunderstandings. This is not just a matter of language. Saudi nurses, because of their background, are also better positioned to share a cultural understanding with their patients. This does not mean that foreign nurses cannot provide good nursing care. However, due to the issues mentioned, they have limitations that will impact on their care.

The ability of a Saudi nurse to understand Saudi customs and traditions helps them act in response to patients' needs. However, as there is conflict in relation to social structure and obligations, Saudi nurses, male and female, find it difficult to continue in their nursing practice.

8.2.1.2 Conflict with Social Structure

Practicing Saudi nurses are not able to feel the same satisfaction and acceptance that nurses in other countries may know. This directly affects nursing's ability to recruit and retain its workforce. The research findings have indicated that nurses perceive conflict between their duties as nurses and their obligations and duties as Muslims: most obviously, in the case of female nurses. Amlak, who has been working in nursing for 23 years, explained that nursing organisations do not concern themselves with issues involving Saudi nurses, such as the social conditions of female nurses, even though the added pressure on female nurses affects their ability to continue in nursing. Other nurses agreed:

> 'Yes, nursing management does not work to improve the Saudi nurse's performance and makes us feel valueless' (Imtinan).

> 'The nursing administration is making it hard for Saudi nurses to attend courses' (Khadijah).

Ali says much the same in expressing the problems Saudi nurses faced with nursing management. He said:

> 'I encountered some difficulties at the beginning and the nursing administration did not take care of me … There is a lack of caring for the Saudi nurse and no administration which is able to understand the nurse and encourage them to work.'

This is supported by Rufaida who said:

> 'I had a problem with the nursing administration and I did not know what to do. When I complained to the hospital administration they told me to 'go to nursing administration, they will solve your

problem. How can I solve my problem with those I am

complaining about? There are no proper channels and the general

nursing administration never care whether you have a problem or

not.'

Imtinan added:

'Management did not find a solution to most of our problems

because they did not care for us as Saudi female nurses.'

The obstacles that Saudi nurses face are different from those in the West,

principally due to the fact that there is no accreditation of nursing courses and the

variation in the education of nurses causes problems in the workplace. Further,

according to Lila:

'Whether we have graduated from a college or HI, our work

assignments are the same. Whether I work in the ICU, medical unit

or at the OPD (Outpatients Department) or work during the day or

night, there is no compensation. There is no extra allowance even

to distinguish employees who have different roles, for example

between a head nurse and an ordinary nurse. They each receive the

same salary.'

Such allowances or penalty rates are available in many other countries. In

Australia, for example, nurses' receive incentives and bonuses and their salaries and

conditions are regulated and protected. In many Western countries, unfair work

conditions can be challenged legally. This has not been the case in Saudi Arabia.

It may be more important to educate the rest of Saudi society so that nurses

can work within a framework that allows them to be nurses free from cultural and

religious criticism. Islamic authorities do not agree when it comes to issues involving a female nurse's education and there is the issue of mixing. Mixing has become an issue because of traditional interpretations of Islamic teaching and it is a significant issue that must be resolved if the lived experiences of nurses are to improve.

Separation of genders means that for Saudis, only male nurses may care for male patients and female nurses for female patients. This is not strictly a Muslim belief but it has become a cultural belief in Saudi Arabia that most Muslims seem to believe has its origins in Islam. The majority of female Saudi nurses refuse to work with male patients (El-Gilany & Al-Wehady, 2002). Gender separation also results in less than adequate communication or information sharing among nursing staff because both staffrooms and recreational areas are segregated. Hospitals require expatriate staff to live in compounds that have strict regulations. For many expatriate nurses, the isolation and restricted movement for women in Saudi Arabia causes problems for them as well. The cultural rules of dress; that is, covering the hair, neck, legs and arms for all women adds to the difficulty (Brown & Busman, 2003; Tumulty, 2001a).

Mixing is usually seen as negative and nursing is seen as mixing. This means the typical Saudi sees nursing as incompatible with Islamic teachings. Due to nursing's association with mixing, the choice of nursing as a profession is enough for the nurse to become the subject of criticism. Female nurses tend to work in PHCCs because they are gender specific and do not require shift work. Female Saudi nurses preferred a regular shift because of social and family obligations (El-Gilany & Al-Wehady, 2002; El-Sanabary, 1993). Amlak reinforces this:

> 'After graduation, most nurses like to work in the health centre as
> work there is easier with work hours suitable for home duties, and
> also you can avoid mixing with men at these centres.'

Working conditions vary from country to country. However, in Saudi Arabia, the prevailing Islamic view of society is more definite, and demanding, when it comes to the roles of women. Saudi society has many expectations of women, as well as men, in the home.

Sarah believed that:

'It is not easy for Saudi female nurses to work eight or nine hours at the hospital. Most female nurses find it difficult to manage this, especially when a nurse is married.'

The work of Saudi female nurses is seen as uncomfortable and lacking flexibility. Even though Saudi female nurses do not work on public holidays, Lila still found:

'The working hours were long compared to other professions such as teaching [where teachers finish work soon after their students do and do not work through the night] … the length of working hours often conflicts with the requirements of the Saudi female nurses at home and this is seen as a barrier … How can I take care of my home if I am working from 3pm to 11pm? These long hours create difficulty for many female nurses and lead to problems for couples. Many female nurses are having continuing problems with their husbands because of this issue and the proportion of divorce among the Saudi female nurses is high' (Lila).

It is important that Saudi nurses, especially females, choose the place in which they like to work. Workplace satisfaction for the Saudi female nurse was found to be significantly higher among nurses working in the more conservative and

suitable working condition (Al-Ahmadi, 2002; El-Gilany & Al-Wehady, 2002).

Findings of research conducted by El-Gilany and Al-Wehady (2002) in the Western

region of Saudi Arabia indicated that 99.1 per cent of the 233 Saudi female nurses

who participated in the study would not accept work in either remote areas or other

regions. Female nurses in other regions had similar attitudes.

This is counterproductive for Saudi society, it makes Saudi female nurses feel

like second class citizens and it is a significant reason for people to leave nursing or

to not join the profession. Saudi nurses are constantly being pushed into situations

where they need to try to explain or justify their involvement in mixing.

'Some of the people in our society are not happy when they learn that

I am a nurse. They even ask, "Why did you choose such a career?"'

(Aisha).

This is an unnecessary distraction from caring. These problems cause

confusion and make the life of a nurse much more difficult.

'However, the issue of mixing is not as clear as it might seem. Ahmad said:

Free mixing in general is something but with limitations it is

something else … Go to Mecca in the holy mosque and you will find

mixing. '

Although Saudi society in general believes mixing is wrong and nursing is

unacceptable because of mixing, there are other examples of mixing that are

accepted. These examples include in the mosque and in professions in other

countries. There are reasons given as to why Saudi society disapproves of mixing;

those who oppose nursing because of mixing should examine these reasons. The

principal reason is that men and women are thought to have an unhealthy (sexual)

influence on each other. The dangers of this should be weighed against the benefits

of nursing. Surely, this would prompt Saudi society to recognise that it is better to

have nurses who are strong enough in their faith to mix without corrupting or being corrupted and that, in fact, we should be thankful for these nurses. Moreover, in so many cases there is no mixing in nursing and every effort is made to enable gender-specific nursing. The real issue is that there are not enough Saudi nurses to implement this segregation effectively.

There are other related issues in which the socio-religious climate of Saudi Arabia affects nurses in a negative way. Family demands on women make it difficult for them to work at certain hours. Many families insist on morning or early afternoon work. The males, too, have family obligations. In the kinship structure, the eldest son is responsible in the father's absence. As men often have to work as nurses six days a week, this is further discouragement for males to take up nursing. Here, it is necessary for nursing authorities to intervene, to establish a system which takes into consideration the expectations of Saudi society. By granting native Saudis more influence in Saudi administration this will happen.

Again, it is necessary to emphasise that the public needs to be taught about nursing. A greater public awareness of the challenges of nursing and the wonderful and necessary work of nurses would lead to more respect and a higher profile for the nursing profession. This would help empower the country's nurses and lead to nursing developing into a highly qualified profession whose numbers could replace the expatriate nurses and deliver high quality care to the people of Saudi Arabia.

8.2.1.3 The Interconnectedness of the Sociocultural Sub-Themes

Within the Value of Caring category, the sub-themes interact in a relationship of dependency. For example, nursing being established from a non-Saudi perspective increases the lack of understanding of what nursing is all about. In this section, I will argue that the influence of social behaviour is not inconsistent with what is

considered correct or unacceptable from a pure Islamic perceptive. The results of this research indicate that a contradiction in the value of caring is caused by misunderstanding nursing work and misunderstanding the conflict between working conditions and Islamic social values. Further, due to the lack of adequately trained Saudi nurses, caring has been established from a non-Saudi perspective.

An analysis of the value of caring illustrates the significance of the attitude of society. In fact, this research indicates the Attitude of the Population is a factor as significant as the Value of Caring and Conflict with Social Structure factors. The attitude of the general population influences the value of caring, as it is the attitudes of people in society that cause misunderstandings and a lack of care for nurses. In turn, problems in the Value of Caring, such as Islamic society's general misunderstanding of nursing and its compatibility with Islamic teaching, affect the Attitude of the Population. Together, these two themes leave nurses in a place in which they do not have enough influence over their situation. Nurses are left feeling uncared for. In their personal lives, they are disempowered and feel like second-class citizens, while in their profession, they are neglected.

The attitude of the general population towards nursing affects the Value of Caring and the Value of Caring affects the Attitude of the Population. Similarly, there are relationships between the Sociocultural sub-themes. As the Value of Caring and Attitude of the Population stand out as significant themes that influence each other, they are each also influenced by the third Sociocultural sub-theme: Conflict with Social Structure.

The Value of Caring sub-theme is concerned with how individuals in society, such as parents, spouses, children and individuals within nursing establishments, especially non-Saudis, have contributed towards contradictions in how nursing is viewed. This creates a Conflict with the Social Structure because it is these

individuals who comprise the social structure in Saudi Islamic society. Likewise, it is the prevailing view of society that influences individuals as mentioned in the Value of Caring sub-theme.

The attitude of the population feeds the misunderstandings about the relationship between nursing and Islamic social values, which is what the Conflict with Social Structure sub-themes is concerned with. The social structure conflicts, in turn, influence the Attitude of the Population.
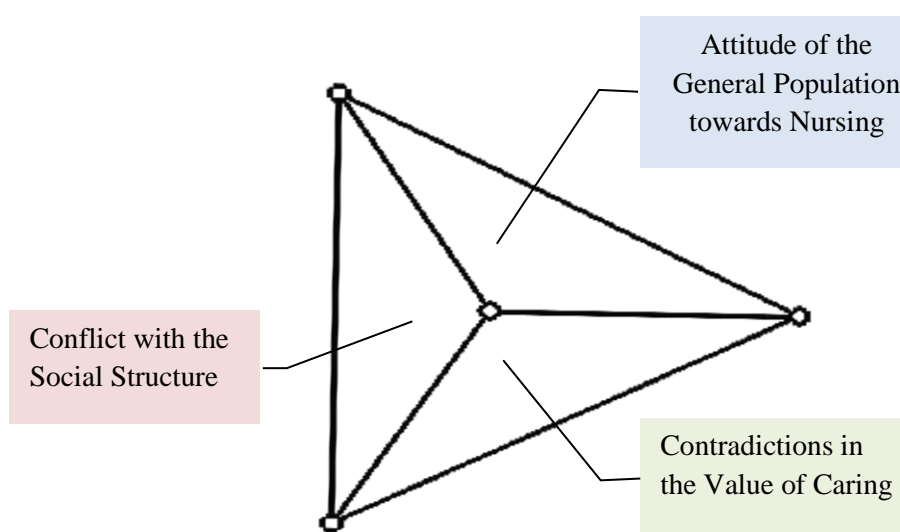
Figure 8.2. The interconnectedness of the sociocultural sub-themes.

As shown in Figure 8.2, together, the three Sociocultural sub-themes—the Value of Caring, Conflict with Social Structure, and now the Attitude of the General Population towards nursing—work together to make the lived experience of Saudi nurses a miserable one. They move in a cyclical fashion, connected like three sides of a four-sided pyramid. The fourth side (the base, hidden in the diagram) could be described as the feeling of powerlessness and a sense of not being cared for as nurses, which this research has indicated to be the lived experience of Saudi nurses. Extending this idea, it is like the Saudi nurse is trapped within this structure and cannot see a way out.

8.2.2 Organisational Paradoxes

There are paradoxes in all aspects of life, including in nursing. These create

confusion for nurses and work against them when it comes to job satisfaction and the

effectiveness of their nursing. These paradoxes are grouped together under the

headings: Paradox of Organisational Commitment, Paradox of Empowerment,

Paradox of Communication and Paradox of Education as shown in Figure 8.3.
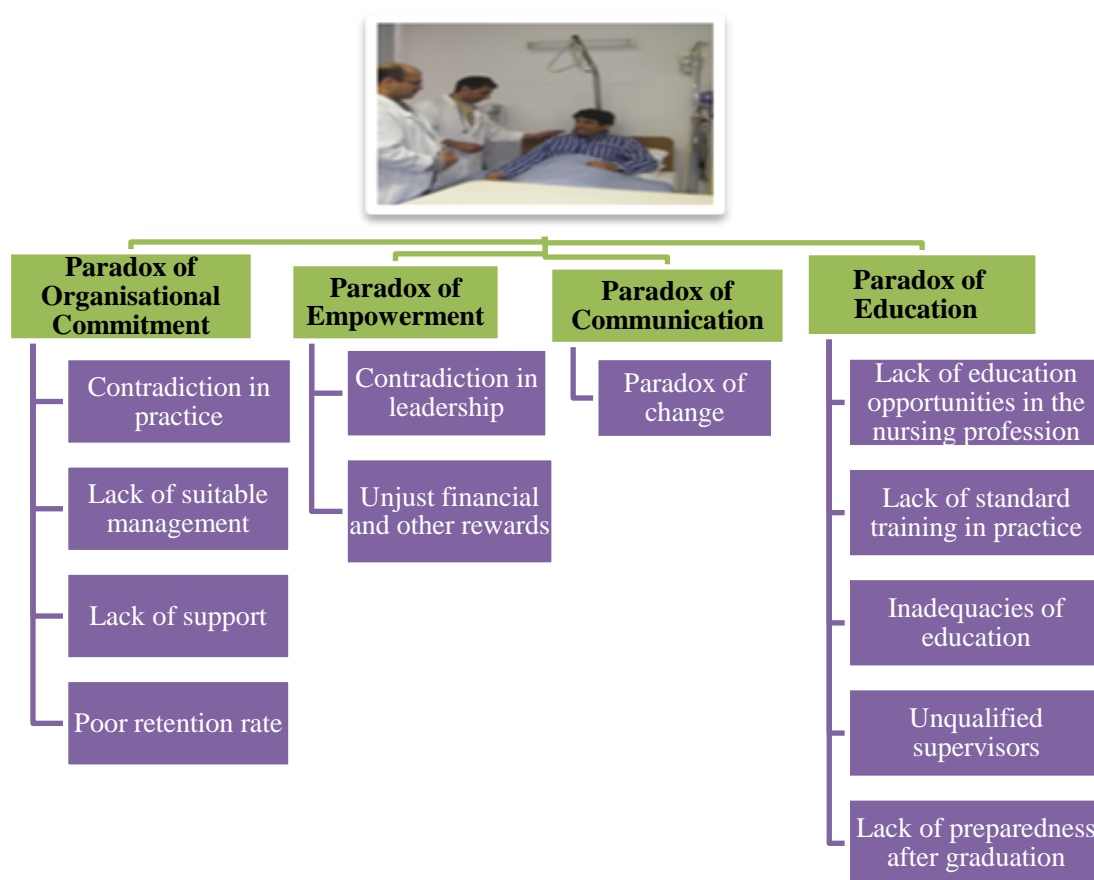
Figure 8.3. The classification of organisational paradoxes.

As with the Sociological factors, as this research has progressed, my

understanding of the Organisational Paradoxes has evolved and my perception of the

relationships between the sub-themes in this area has altered slightly. The

Organisational Paradoxes displayed in Figure 8.3 again depict contradictions in

Saudi nursing, but from within nursing and nursing organisations. These findings are

similar to the results mentioned in a number of research studies.

Many researchers have argued in favour of organisational commitment emphasising understanding the factors that can influence commitment, as it would broaden our understanding of the organisational construct and their interrelationships. For instance, Al-Ahmadi (2009), Khatibi, Asadi and Hamidi (2009) and Darwish (2002) have found a positive relationship between organisational commitment and job satisfaction. A positive relationship was also found between organisational commitment and employee behaviours such as a greater effort by the employee in performing tasks, higher employee retention, better work attendance, increased willingness to engage in teamwork and higher delivery of quality service (Nehmeh, 2009).

The stories of the participants present conflicting pictures of nursing. This conflict presents difficulties in a profession that is determined to maintain legitimacy in increasingly uncertain times. However, I argue that the implications of my research do not undermine notions of professionalism in nursing. Being aware of the problems in one's profession can be a strength. Depending on the reactions of nursing groups to some of the problems raised in this research, Saudi nurses can come to be better prepared to deal with challenges arising in their education, practice and management.

One area in which paradoxes are apparent is in nursing management. One of the roles of nursing management should be to support nurses and represent their interests. However, in KSA, there are unequal power relations between nurses and their practice. This power imbalance impacts the Saudi nurses' commitment and access to education, key resources, research, information and their practical communications.

8.2.2.1 Paradox of Organisational Commitment

The MOH has been unable to adequately educate, manage, attract and retain Saudi nurses. Saudi nurses are leaving their profession despite their being best placed to care for the Saudi public and despite a Saudisation policy that aims to increase Saudi nurses in the workforce. Hofmann (2001, p. 369) points out that modern health care appears to be rich in contradictions. In particular, he claims that 'health care is held to be a paradox itself: it is supposed to do good, but is accused of doing harm'. According to Naresh, Brown and Hicks (2009), health care organisations are finding it hard to move from a culture of accountability to a just culture, to the culture of safety in the nursing practice (Scott-Cawiezell et al., 2006).

Nursing as a profession aims to meet the holistic needs of both Saudi nurses and Saudi patients—but does this happen? The conflicts and stress among nurses, due in large part to the contradictions in nursing, are many. The participants believe, or have had put to them by others, that the Saudi nurse should work harder than the non-Saudi nurse. Some of the nurses interviewed blamed expatriates for not being supportive, others blamed nursing management and insufficient nursing policy, and others blamed inadequate education and training. In all these areas there are contradictions between what should be happening and what is happening.

In modern society, either in the West or in the East, there is often a gap between the management of an organisation and the front-line staff of that organisation. If working conditions are suitable, then it is difficult for external factors to negatively influence the workplace. However, when the management of an organisation is distracted by a desire for profits or convenience or by directors who lack suitable experience, contradictions occur.

8.2.2.2 Paradox of Empowerment

There are paradoxes in nursing management. Management is meant to be involved in all aspects of nursing. For nursing to be an efficient profession, management must also represent the interests of nurses. Management must function for and on behalf of nurses if they are to achieve the job satisfaction that will keep them in nursing. Unfortunately, in the current system, unequal power relations exist between nurses, their practice and management. Waleed said:

> 'There is some kind of mismatch in nursing work. There are
> problems between nursing and administration and between the
> nursing administration and hospital administration at the hospital.
> There is something missing between the boss and the subordinates.
> In most cases, the boss is a foreigner and he does not observe
> conditions and circumstances related to Saudi nurses.'

This power imbalance, perceived by participants, impacts the Saudi nurses' access to education, key resources, information and their practical communications. Consequently, a Paradox of Empowerment goes hand in hand with irritation and frustration in nursing. In Amlak's words:

> 'According to my experience in nursing, and my work in this field
> [23 years], the Saudi [female nurse] is able but their status must be
> improved and problems in nursing must be solved.'

Further, Reem pointed out:

> 'Saudi nurses face problems with shifts and the nursing work does
> not fit the conditions of the family and home. Work hours are long
> and there is no any consideration for family circumstances.'

Nurses in Saudi Arabia need more than discussion about development, they need actual planned development; in other words, they need leadership. Marquis and Huston (1996) describe empowerment as a necessary aspect of transformational leadership, which gives accountability, responsibility, knowledge and authority to nurses to take on the work that needs to be completed (Speedy & Jackson, 2004; Leach, Wall & Jackson, 2003). This Paradox of Empowerment stands out as a major issue. In the sections to come, it will be suggested that it is an essential element of the findings.

8.2.2.3 Paradox of Communication

In Saudi Arabia, it is important for a nurse to speak and understand English because this is the language used in the health care facilities. It is also important for nurses to speak Arabic to deliver appropriate nursing care to the population. This becomes a complex paradox, with misunderstandings often resulting from poor communication. While Saudi nurses find it difficult to communicate with expatriates, Saudi patients also find it difficult to understand nurses. Imtinan said:

> 'Most expatriate nurses ignore the patients simply because they do
> not understand them. The nature of illness must be known before
> we deal with the patient. If you do not understand what the patient
> is complaining about then you are ignoring the patient's rights.'

In this respect, this research reinforced already common knowledge: that communication is vital for patient care and nurses' work performance. In Saudi Arabia, most of the patients are illiterate and many nurses are not competent In English. Communication skills need to be improved. However, this change needs to be planned and is dependent on increasing the number of Saudi nurses. Health care facilities need to have nurses who can speak the native language and in the meantime

Saudi nurses should have courses to improve their English skills. Further, nurses who train in HIs, like those in health colleges, should be taught in English as long as English remains the language of health care.

When operating in a second language, the differences in the foundation of different languages may cause us to misinterpret the meaning of words we hear and affect our understanding. These differences are very much cultural differences. According to the ANA (1991), the impact of culture as a causative influence on the perceptions, interpretation and behaviours of individuals in particular cultural groups is important. This impact affects language. Schneider (1994, p. 3) stated that, 'language includes a vocabulary [words] not just of terms, but of conceptual, organizing ideas'. Culture affects language and language affects nursing. If nurses do not know the language of those they are nursing, then the quality of their care will be diminished.

One concern arising from this research is how much our common language (Arabic) obscures our understanding of each other and of nursing. There is significant conflict between having a multilingual workforce and the language of the hospitals being English. It is not only Saudi nurses who suffer from language and thus cultural difficulties; all nurses in Saudi Arabia do, and this impacts on their ability to provide care. For the majority of nurses, both Saudi and expatriate, English is a second language and differences in English fluency clearly affect the quality of communication between nurses, patients and other health professionals.

Saudi and expatriate nurses face different issues when providing nursing care to the Saudi population. Since Saudi nurses find it difficult to understand the language of their practice, it is understandable that they will find it harder to carry out that practice. Saudi nurses are compelled to become skilled at and communicate in English if they want to practice nursing effectively. However, while English is

important to understand as the language of communication used by staff in the workplace, it should be essential to be able to comprehend Arabic, due to this being the language of the majority of patients.

8.2.2.4 Paradox of Education

Improving nurse education is vital. Nursing education needs to have a coordinated approach and the organisations responsible for it need to work together with similar standards. As it is, nurses become frustrated when they do not have the standard of learning necessary to effectively carry out their duties. Saudi nursing programmes have for the most part had an unspecified and uncoordinated approach to education and training. There are not enough nursing courses in the institutes, colleges or universities. It is even harder to find a Bachelor Degree to study. Colleges and institutes are usually focused on the study of medicine and there are few suitably qualified Saudi nurse educators.

Currently, many applicants are being denied places to study nursing. If more courses were made available and taught to higher standards we would move towards better nursing in Saudi Arabia. Poor training breeds disrespect: a serious problem in the current state of nursing. Increased levels of training will produce better, more capable nurses, which is what is needed now. Further, increasing the quality of training and the availability of training opportunities should stop nurses leaving their profession. However, it is important that the nursing colleges and universities offering nursing education programmes be distributed throughout the Kingdom, because females especially find it difficult to travel for study.

The experiences of nurses have allowed them to see the weaknesses in the education system. However, not enough Saudi nurses are involved in this system to be able to bring about the desired changes. Saudi nurses, rather than expatriates,

should be directing the needs of nursing in Saudi Arabia. They should have control of education in the institutions, on-the-job and in further training courses.

The private institutions appear not to care enough about the interests and needs of Saudi nurses. Therefore, the question is raised: Do they care enough about meeting the needs of the public in Saudi Arabia? Private organisations are designed to make a profit. As such, making a profit has the potential to be at the expense of quality nursing standards. Private institutions are not answerable to Saudi nurses, but they need to be. Existing private institutions need government intervention to help them raise their standards of teaching. Many of the nurses interviewed indicated this:

> 'Management doesn't want the success of the Saudi nurse because management is not qualified. They do not want anyone to occupy the management chair except them' (Ahmad).

> 'Since management is in the hands of expatriates they do not really know exactly what the social life of a Saudi male or female nurse is like. The nursing administration in the hospital did not encourage Saudi nurses and they continued supporting the expatriates because they feel they are better than Saudis. We lacked the moral encouragement and compliments form nursing management' (Imtinan).

> 'Now, the main problem we have is related to graduates of the private institutes … The standard is low, and they do not have the necessary skills. Language is also difficult for them. I think that study at the private institute was of a lower standard than that at the HIs affiliated with the MOH … The nursing department throughout the Kingdom lacks the right people' (Waleed).

Sami added that the private institutions had unqualified teachers and untrained supervisors, stemming from a nursing management comprising too many expatriates. Expatriates are not familiar enough with Saudi needs. According to nurses such as Waleed, they do not make decisions that are best for Saudi nursing. He said:

> 'We don't have plans for nursing. We lack plans because we lack
>
> the competent people who are able to develop nursing. When we
>
> have plans and strategies, the situation will get better. We need
>
> Saudi leaders who are able to effect change and development.'

Saudi nursing needs to be run by Saudis for Saudi nurses and both the Saudi people and others living in Saudi Arabia. Educational services ignore the cultural experiences of Saudi nurses, which differ significantly from the majority of the population. The nursing environment consists of a variety of nursing staff from many different countries. This represents a rich gathering of perspectives and skills. However, these perspectives and skills need to be used within a nursing framework that caters to the specific cultural needs of nursing in Saudi Arabia. This involves understanding Saudi culture and the cultural needs of the nurses and their patients. It must also include being able to communicate well with the Saudi patients. Only in this way can the nursing workforce issues be resolved harmoniously.

In the multiethnic workforce of nursing in KSA, cultural competence is important. In nursing, this means having the beliefs, knowledge and skills necessary to work effectively with individuals different from oneself (Naresh, Gordon & Hicks, 2009; Krentzman and Townsend, 2008; Leininger & McFarland, 2002). Jeffreys (2006, p. 24) adds that confidence—clearly connected to a nurse's job satisfaction—is a vital component in the process of learning cultural competence.

There is a significant need for professional development processes to rapidly integrate cultural competencies into education and training. According to Jeffreys (2006, p. 24), for health care education and health care professionals, the challenge is to provide educational opportunities to enhance cultural competency so that quality outcome indicators such as enhanced client satisfaction and positive health outcomes may be achieved. If Saudi and expatriate nurses worked as a team, under careful guidelines aimed at improving the standard of Saudi nursing and increasing job satisfaction and nurse retention rates, then changes could be expedited while Saudisation occurs. While currently, this is not being done, it is hoped that nursing administators will consider this proposal.

Nursing accreditation is also essential. Other countries have accreditation that ensures minimum standards that must be achieved in nursing education and nursing in Saudi Arabia must adopt this policy as well. Without accreditation of set standards in nursing education, nursing educators cannot ensure a satisfactory education for their nurses. Nursing bodies need not wait for the backing of government to move towards set standards and accreditation for universities, institutes and colleges, based on their ability to teach at the accredited standard.

8.2.2.5 The Interconnectedness of the Organisational Paradoxes Sub-Themes

The Paradox of Organisational Commitment is about management that currently has no national direction or accountability. This is affected by poor communication caused by the language used in nursing. Amlak said, 'difficult communication impedes participation in most cases'. Lila also spoke about her problems with understanding the language:

> 'I experienced some difficulties at the beginning. For example,
> difficulties in understanding the expatriate nurses as well as my
> duties. This often caused problems with the patients, visitors and
> some of the doctors.'

Waleed stated:

> 'Starting nursing was difficult, particularly in relation to
> communicating in English.'

A lack of communication affects organisational commitment in many areas that, in turn, has an ongoing impact on nurses. Management decisions about the language to be used in nursing also affect Education, in which they influence the quality of learning of nurses in training as well as their competence on the job. The Paradox of Education in turn affects Organisational Commitment, as seen by the inadequate, unqualified or ill-equipped nursing bodies in charge of nursing. The Paradox of Education also has a significant impact on Communication. Similarly, Communication issues determine problems in Education.

The Paradox of Empowerment is linked in a similar way to each of the other sub-themes. The other sub-themes all impact on the sense of hopelessness of Saudi nurses and take away much of the control nurses might otherwise have on their destiny—on their roles as Muslim nurses and their lived experiences. However, rather than influencing the other themes in a similar way, a Paradox of Empowerment is more like an outcome, or a consequence, of them. The Paradox of Empowerment is the emergent essence of this classification.

The interconnectedness of the Organisational Paradox sub-themes is circular, with each sub-theme linking with the others. It is important to remember that the interaction of the other sub-themes with the Paradox of Empowerment goes one way.

Figure 8.4 depicts the relationship between the paradoxes of communication, education and organisational commitment, to illustrate the tyranny of neglect in nursing.
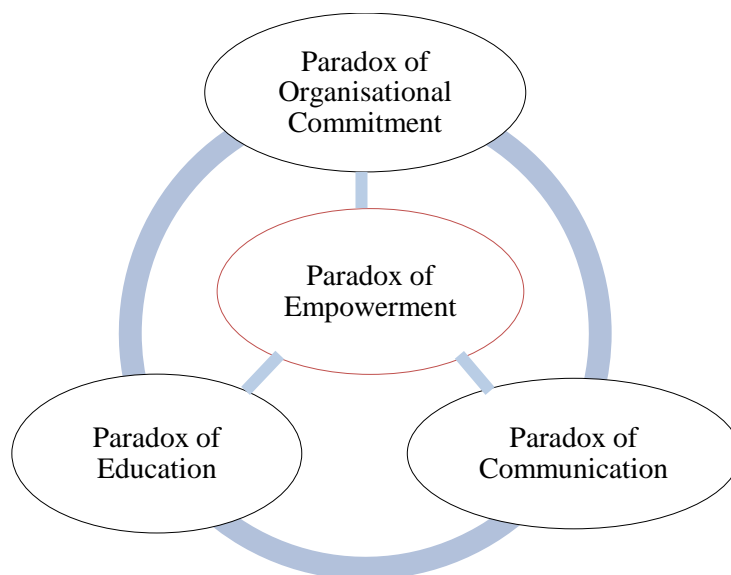
Figure 8.4. Organisational paradoxes and a lack of empowerment.

Figure 8.4 shows the relationships between the sub-themes within the Organisational Paradoxes classification. A Paradox of Empowerment is shown as the central outcome of these sub-themes. The model of Empowerment in Figure 8.5 describes the relationship between the sub-themes and the final outcome.
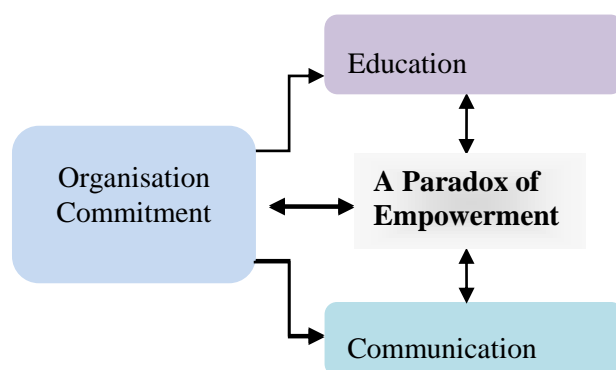
Figure 8.5. A model of the paradox of empowerment.

The next figure, Figure 8.6, illustrates the sociocultural factors and how they contribute to neglect.
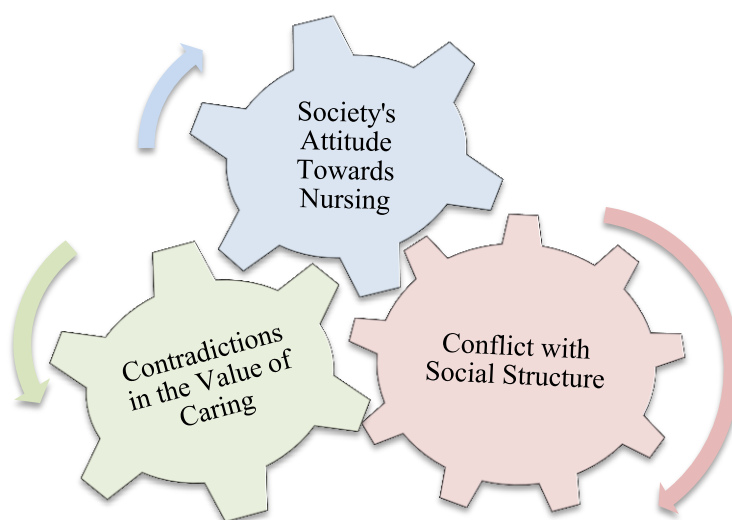
Figure 8.6. Sociocultural factors and the mechanism of neglect.

As shown in Figure 8.6, the three sociocultural themes—the Value of Caring, Conflict with Social Structure and the Attitude of the General Population towards nursing—work together to make the lived experience of nurses a miserable one. In the diagram they fit together like cogs in a machine, illustrating their connectedness as well as their power in influencing each other. Note in the figure that the Society's Attitude Towards Nursing cog is dysfunctional, with the other factors pushing to turn

it in different directions. This accurately represents the relationship between these issues.

8.3 The Essence of the Research Findings

The relationship between the sub-themes in both the Sociocultural Factors and the Organisational Paradoxes is generally one of interdependence. However, there are two factors that emerge as outcomes of all the sub-themes. The first is that nurses have a sense of powerlessness in the face of all their problems and the second is that they have a sense that no-one cares. These outcomes summarise the main results, or essences, of this research. They can best be expressed within two powerful words, Disempowerment and Neglect. These two concepts underlie all the objective information collected: they are at the heart of the words of the participants and form the essence of the research. They describe what the nurses are saying—that their lived experiences being nurses have not been pleasant and that much reform is needed in the nursing profession in Saudi Arabia.

It is difficult to say which has more significance. Just as the sub-themes form interdependent relationships and influence each other, these two 'essences' are mutually reinforcing. In many ways they are part of the same problem, with neither being more significant than the other. Unlike the sub-themes that influence each other, these 'twin essences' do not influence the sub-themes, but they are at the centre of them, as the outcome or end result of all the themes and sub-themes.

Neglect leads to disempowerment. Just as a child, if not looked after, will not be taught or be given the skills it needs to grow. Disempowerment leads to neglect, as a child who is not allowed to learn and grow will not be raised with knowledge, wisdom and contentment. Nursing in Saudi Arabia is like this. The neglect has stopped the growth of the nursing industry. Within the industry there is chaos and

inefficiency because nursing and nurses have not been well-informed or managed properly. The result is the high rate of attrition, the difficulty of recruiting more nurses, the unhappiness of practicing nurses with their profession and their unhappiness with how nursing is viewed as a profession.

Saudi nurses are disempowered in that they want to do their work well and enjoy the lived experience of being a nurse. They want to be of benefit to society and respect their Islamic nature. However, they have generally found that there is little they can do to improve the nursing situation and achieve the outcome they want.

8.3.1 A Summary of the Relationships between Themes

One revealing way of describing the phenomena diagrammatically is by showing the interconnecting Sociocultural themes on the left, the interconnecting Organisational Paradoxes on the right and the two twin essences in the middle. Figure 8.7 below illustrates this and connects the themes and sub-themes with arrows to indicate the patterns of influence.
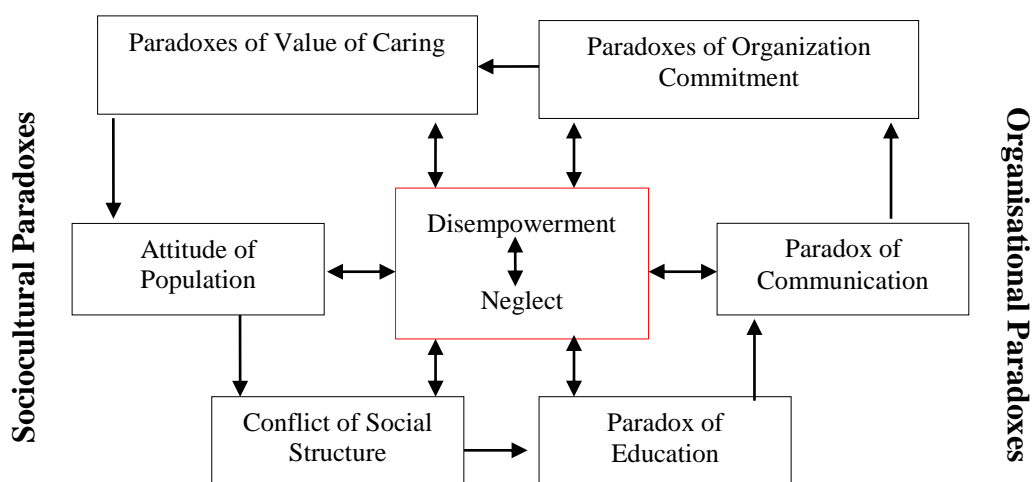

Figure 8.7. A synoptic view of the hidden aspect of the research findings.

Disempowerment and neglect are at the centre of the diagram because they have evolved from a phenomenological perspective to become the central outcomes of the research. The energy of the sub-themes is shown with arrows as moving back

and forth from one to the other. The end point of the movement of all energies (influences) is at the twin essences of Disempowerment and Neglect, which represent the essence of the reported lived experience of Saudi nurses.

This diagrammatic representation shows the themes—Sociocultural Factors and Organisational Paradoxes—connected primarily by Conflict with Social Structure influencing the Paradox of Education, with the Paradox of Organisational Commitment influencing the Value of Caring. Figure 8.7 is a summary representation of the phenomenological 'objective information' collected. There can be arguments for arrows connecting the sub-themes in different ways. However, this may only complicate the end result and weaken what we gain by this depiction.

In phenomenological research, where the thoughts of the individual are complex, transferring the 'objective information' from written statements to graphic form is also complex. The graphic representation of the research findings is a summary only, used to illustrate the primary linkages between the themes, sub-themes and the twin essences. This is why the link, obvious when reading this research, has not been shown between the Value of Caring and Conflict with Social Structure, or between the Paradox of Organisational Commitment and the paradox of Education. The links do exist and are just as significant as the connections between the other sub-themes. Organisational Commitment and Education clearly interact with each other, as it is on an organisational level that education originates, and from an organisational standpoint that it must be monitored and improved. The Value of Caring and Conflict with Social Structure interact with each other the way society and its members do in any situation. If nurses are not understood and cared for and are neglected in their profession, then the Social Structures around them will not see them clearly. If the Social Structures do not understand nurses, then nurses and their needs as nurses in an Islamic society will not be adequately cared for.

This diagram is useful in its representations, as it shows a close relationship between sub-themes, illustrating the nature of the data. The words expressing the data all speak of related phenomena, and what they represent cannot be spoken about in isolation. Everything in the diagram is connected. It represents an attempt to venture into the minds of the participants of this research and represent the findings in a clear and simple manner.

8.3.2 Review of the Twin Essences

Nursing as a profession has been the subject of a great deal of misunderstanding and misinterpretation. Accusing Saudi nurses of being unsuitable for nursing and holding incompatible values is not a new phenomenon. Throughout the history of nursing in Saudi Arabia, the expatriate has had a central role in nursing. Saudi society sees nursing in negative terms as an unskilled occupation below the dignity of most Saudis and better left to foreigners (El-Sanabary, 1993, p. 1337). The neglect of Saudi nurses has been ongoing. The perception of nursing as being associated with menial work and requiring little intelligence or education reflects ignorance of this profession.

Nursing organisations themselves have been major contributors to the painting of this widespread and inaccurate image of nursing in Saudi Arabia. It is ignorance of the reality of nursing as a caring profession and ignorance of the concept of caring as being a fundamental concept in Islam that has created this situation and fuelled the neglect of nurses. In fact, in the name of their profession, nursing management has adopted ideas and taken actions that have nothing to do with the betterment of nursing in Saudi Arabia or with Saudi nurses.

8.4 Disempowerment and Neglect

Disempowerment is the taking of 'power or authority away from' someone (Macquarie Concise Dictionary, 2006). Under the heading, 'self-empowerment a must for Muslims', *The Times of India* (2010, p. 1) reported the words of social activist Nafisa Ali, who said, 'We must understand the importance of education for economic as well as social empowerment. It [is] imperative that all children from the community receive an education'. Disempowerment is not compatible with a profession that seeks to offer care to the community.

8.4.1 What is Empowerment?

According to Blanchard, Carlos and Randolph (1999, p. 2), 'too many managers view empowerment as giving people the power to make decisions'. Empowerment is much more than this. Empowerment is having the ability to do what you need to do in the society in which we live. Empowerment also involves opportunity, that is the opportunity for nurses to work towards what they want. Richardson, MacLeod and Kent (2010, p. 130), in their phenomenological research, concluded that 'empowerment must not be something that simply occurs from within, nor can it be done by another'. Richardson et al. (2010, p. 134) cited Cumbi (2001) to say, 'empowerment describes the intentional efforts to create a more equitable relationship and a living within someone else's world'.

Rodwell (1996), who analysed the concept of empowerment and its use in nursing practice, education, research and health promotion, concludes that 'empowerment is a helping process'. An enterprise valuing self and others, mutual decision making and self-determination to make choices and accept responsibility has implications for practice (Rodwell, p. 305), given that it requires the professional

to have capability, initiative, commitment and independence in decision-making, which organisational structures may impede (Speedy & Jackson, 2004, p. 60).

8.4.2 Disempowerment of Nurses and Burnout Syndrome

Recent phenomenological research indicates that 'disempowerment occurred where participants referred to a lack of impact, their action having no effect, or achieving nothing (Drury, Cocking, Beale, Hanson & Rapley, 2005, p. 318). Drury et al. (2005, p. 319) reveal that after participating in empowering experiences, their participants described positive feelings, including confidence, pride, enthusiasm, joy, feeling good and being on a high. The authors claim that 'the most common word expressing how participants felt was encouragement' (Drury et al., 2005, p. 319). When asked how the participants felt emotionally after disempowering events, they referred to feeling discouraged, demotivated, upset, fearful and disappointed (Drury et al., 2005, p. 321).

Powerless nurses are ineffective nurses. Powerless nurses are less satisfied with their jobs and more susceptible to burnout and depersonalisation (Manojlovich, 2007; Burke, 1998). Burnout Syndrome (BS) is a term used to describe the state of nurses (and other employees) when the stress of their profession has got the better of them and they can no longer function. 'Burnout differs from depression in that it involves a person's relationship with work' (Abdulaziz, Baharoon & Al Sayyari, 2009, p. 218). BS appears to be more common in Saudi Arabia than in other countries (Abdulaziz, Baharoon & Al Sayyari, 2009; Burke, 2000).

Research conducted by Al-Turki, Al-Turki, Al-Dardas, Al-Gazal, Al-Maghrabi, Al-Enizi and Ghareeb (2010) assessed the prevalence of BS among a multinational nursing workforce in Saudi Arabia. They found the majority of the nurses (Saudi and non-Saudi) were in a state of burnout, with a high frequency of

emotional exhaustion and depersonalisation. The working conditions were found to significantly affect BS. Sarmiento, Laschinger and Iwasiw (2004) have also undertaken a study of BS. Their research shows empowerment (or disempowerment) to be significantly related to burnout in nursing and that it is most strongly related to emotional exhaustion and depersonalisation.

8.4.3 The Need to Empower Saudi Nurses

The key to the findings of this research is empowerment. According to the essences of the research findings, the sociocultural and organisational paradoxes, along with lack of nursing support and disempowerment, have impacted on the Saudi nurses' self-esteem. Little has been or is being done to improve Saudi nurses' self-esteem and this causes stress and staffing shortages (Burke, 2000; Tumulty, 2001a). This all leads to health conditions that affect personal wellbeing (Burke, 2000), decrease the quality and efficacy of patient care (Almeer, 1995; Gillespie, 2003) and increase the level of stress (Khatibi, Asadi & Hamidi, 2009).

The impact of workplace conditions on nurses' burnout is well-documented in nursing literature (Abdulaziz et al., 2009; Al-Turki, Al-Turki, Al-Dardas, Al-Gazal, Al-Maghrabi, Al-Enizi & Ghareeb, 2010; Laschinger, Finegan & Wilk, 2009; Laschinger, Wong & Greco, 2006). Burnout as a concept is related to the essence of these research findings, as Saudi nurses need to be empowered to continue working.

Hall (2007, p. 68) claims that, 'organizational and managerial support have an effect on nurse satisfaction and burnout'. Findings from a study by Greco, Laschinger and Wong (2006) suggest that the leader's empowering behaviours can prevent burnout and increase empowerment.

Power is central to nursing's development as a profession (Hajbaghery & Salsali, 2005; Richardson et al., 2010; Speedy & Jackson, 2004; Wolfe & Fetzer, 2006). Casey, Saunders and O'Hara (2010, p. 34) state,

> 'Managers at all levels must attend to critical social empowerment as well as structural empowerment in order to increase job satisfaction, retention and engagement of highly qualified committed nurses and midwives.'

As health care professionals, we need to think more about power and control issues in our lived experiences. Many authors have emphasised understanding the concept of power as an essential requirement of any empowerment plan (Drury, Cocking, Beale, Hanson & Rapley, 2005; Hajbaghery, Salsali & Ahmadi, 2004; Leach, Wall & Jackson, 2003; Manojlovich, 2007; Richardson et al., 2010; Rodwell, 1996; Speedy & Jackson, 2004). Richardson et al., (2010) state:

> 'Thinking about power and control, and finding it in their own lived experiences, will empower nurses so that they are better able to find satisfaction in their work, and better able to meet the needs of their patients' (p. 134).

Leach, Wall and Jackson (2003) found a clear link between psychological empowerment and professional or situational empowerment. They state that psychological empowerment is 'a consequence and necessary adjunct to situational empowerment' (p. 28).

An exploratory model of empowerment has been tested in a Taiwanese sample of school health nurses. Chang, Shih and Lin (2010) examined the mediating role of psychological empowerment in the relationship between external factors and

work-related attitudes, specifically job satisfaction and organisational commitment. They found that psychological empowerment did not fully mediate the relationship between organisational empowerment and job satisfaction because of the strong direct effects of organisational empowerment on job satisfaction. The influence of empowerment on organisational commitment was mediated through job satisfaction (Casey, Saunders & O'Hara, 2010; Chang, Shih & Lin, 2010). Empowerment has important outcomes in many organisational contexts and it is clearly associated with commitment and job satisfaction (Al-Aameri, 2000; Birdi et al., 2008; Bradbury-Jones, Irvine & Sambrook, 2007; Hajbaghery & Salsali, 2005; Smith, Andrusyszyn & Laschinger, 2010). Clearly, neglect in the workplace is not a problem that can be resolved just with psychological empowerment; the workplace must be changed too.

In Saudi Arabia, nurses' job satisfaction and organisational commitment are found to influence organisation performance and productivity (Al-Aameri, 2000) and decision-making and responsibility (Altallal, 2006). Moreover, job satisfaction has been found to be positively associated with contradictions in the workplace involving patient satisfaction and quality of care (Al-Aameri, 2009; Al-Hosis, 2006; McNeese-Smith, 1996).

8.4.4 Neglect Stems from Disempowerment

Disempowerment and neglect are negative characteristics that impact on nurses psychologically and affect their behaviour. Phenomenological research carried out by Bradbury-Jones, Sambrook and Irvine (2010) explored the empowerment of nursing students in clinical practice and found that being valued as a learner, being valued as a team member and being valued as a person are important factors in the empowerment of nursing students in clinical practice. One significance

of this is that being valued is an important element of empowerment (Bradbury-

Jones, Irvine & Sambrook, 2010).

Qualitative research conducted by Hajbaghery and Salsali (2005) found

personal empowerment, collective empowerment and the culture and structure of the

organisation to be the main categories for empowering nurses in Iran. The authors

claim that empowerment is a dynamic process that results from mutual interaction

between personal and collective traits of nurses as well as the culture and the

structure of the organisation. Opposing this, they argue that power dynamics within

the health care system hinder nurses from demonstrating that they possess the

essential ingredients of empowerment (Hajbaghery & Salsali, 2005).

The neglect of Saudi nursing comes from the inadequacies of nursing

organisations and a lack of consideration of Muslim beliefs. It comes from the lack

of power nurses have in almost every aspect of both their personal lives (because

they are nurses) and their nursing lives. It does not matter if the Saudi nurses are men

or women; both groups have their problems, many of which are shared. This is the

essence of the findings of this research. There is no evidence to show that there has

been any successful attempt to improve the situation or deal with the neglect and

limited resources with which Saudi nurses must deal. In general, Saudi nurses are

severely challenged by the sociocultural factors and organisational paradoxes.

Nursing, as a profession is lacking a suitable guiding principle. As a caring

society, Saudi Arabia has not yet achieved its aims for nursing. Saudi nurses should

be working in a profession that meets their needs socially as well as allowing them to

achieve their goals effectively and professionally. Saudi nurses can play an important

role in determining the value and future of health care in Saudi Arabia, and many

authors argue that nurses have the potential to be part of solutions to key problems in

health care systems (Hajbaghery & Salsali, 2005; Speedy & Jackson, 2004; Al-Aameri, 2000).

8.4.5 Phenomenology and Saudi Culture: The Concept of Empowerment

According to Richardson, MacLeod and Kent (2010, p. 134), typically the clinical world has its own customs and culture that can be difficult to understand'. Saudi culture is inseparable from the religion of Islam and to understand the sociocultural factors that influence Saudi nurses' desires and abilities, it is important to know the rule of Islam and its relation to all aspects of life. Islamic law is deeply rooted in the Holy Qur'an and the narrative of the Prophet of Islam (PBUH). Islam is a religion that not only governs the private religious life of an individual, but also commands and regulates all aspects of life in society (Doumato, 1999; Voig, 2005). It is important in Saudi Arabia to know, and respect, the culture of Islam. Islam is about care:

> 'The one whose main concern is this world has nothing to do with
> Allah [God], and whoever does not fear Allah has nothing to do
> Allah, and whoever does not care about the Muslims is not one of
> them' (Narrated by Al-Bukhaari (6011) and Muslim (2586) as
> cited in Al-Munajjid (2011, p. 1).

The Saudi culture is a strict one that clearly states that Muslims are not Muslims if they do not care for each other. This is so prominent, so important for Saudis, that it goes hand in hand with worship of Allah (Almighty)—caring is equivalent to serving Allah (John & Esposito, 1994; Voig, 2005).

The incorporation of the Saudi culture into the nursing profession is important to the development of nursing in Saudi Arabia. The value of caring from Islam overlaps with values relating to constitutional equality that involve the identity

of Saudi nurses. Constitutional equality embraces Islamic values (Voll & Esposito, 1994). These values, which relate to the identities of Saudis, involve such aspects as language, gender, science, morality and ethics. From the findings of this research, one can suggest that there are many values that seem to be requisite for sustainable equality in the nursing organisational system. An example is the ability to comprehend the Arabic language—essential for an understanding of Saudi cultural values and effective communication with the patients in Saudi society—which is currently missing from the nursing profession.

Nursing is meant to be a caring profession. Its origins lie in a desire to meet the intentional aspects of the Islamic religion and culture concerning the needs of the sick and wounded. It is a profession designed to help with healing and provide comfort. This has been known since the time of the Prophet of Islam (PBUH). Therefore, it is important that Saudi nurses apply the concept of caring from their Islamic perspective. Saudi nurses can satisfy their patients' needs and be effective nurses by using their own critical self-reflection, particularly when seeing, listening, reading and thinking, and by using their experience and intuition (Cumbi, 2001; Lyneham, 2004; Richardson, MacLeod & Kent, 2010). Those nurses who feel strongly for their patients and take pride in their nursing spend time looking around, listening and feeling: compassion is viewed as important and they are concerned about the concept of intuitive experience, thought and knowledge (Lyneham, 2004). Nurses want nursing to be a caring profession. Instead nursing is typified by neglect and a lack of critical self-reflection.

The Prophet (PBUH) said:

> 'The likeness of the believers in their mutual love, mercy and
> compassion is that of the body; when one part of it is in pain, the
> rest of the body joins it in restlessness and fever' (known Hadith

narrated by Al-Bukhari (6011) and Muslim (2586) as cited in Al-Munajjid (2001, p. 4).

It is easy to see in the Qu'ran that Islam, as a culture and a religion, should promote the science of nursing and empower nurses, not neglect them. Muslim values do not prevent the establishment and implementation of nursing theory and practice. In fact, Muslim values initiated nursing in our culture (Al-Hayani, 2005; Al-Ghazali, 1970). The relationship of Islam to democratic institutions in society is considered to be appropriate (Voig, 2005; Voll & Esposito, 1994). However, the law of Islam does not empower the system of management with the right to disempower Saudi nurses, nor does it justify neglect of the rights of their profession. Rather, Islam gives powerful consideration to our conduct, and self-belief must be essential in deciding the validity of our actions (Al-Ghazali, 1970). According to Al-Hayani (2005), any scientific discovery must emanate from a value system or base. Muslims must treat scientific knowledge as a trust and, as such, hold it in accordance with the laws of Islam (Al-Hayani, 2005; Al-Ghazali, 1970).

The notion of worship in Islam is not restricted to mere rituals, but is inclusive of all deeds of obedience and goodness, with the concept of religion extending to all possibilities of life in the world (El-Affendi, 1999; Robert, 1999; Voig, 2005; Voll & Esposito, 1994). 'Religion has been regarded by sociologists generally as a conservative force, supportive of established interests' (Berger, 1967, as cited in El-Affendi, 1999, p. 200).

There is strong evidence in the Holy Qur'an to indicate that science is in harmony with Islam (Al-Hayani, 2005). The Holy Qur'an and the Prophet (PBUH) make clear that knowledge and its acquisition is required of all Muslims. In addition, the Prophet made learning obligatory for both males and females (Al-Ghazali, 1970). According to Al-Hayani (2005), this implies that though the road for the acquisition

of knowledge may be extremely difficult, Muslims must negotiate it. The Prophet urged Muslims to acquire knowledge and learning from the cradle to the grave, making it the duty of Muslims to seek knowledge in all spheres of life and in all disciplines (Al-Hayani, 2005). Muslim scholars believe that 'with God's help and guidance, our task is to create a better and healthier world for all of humankind' (Al-Hayani, 2005). In the Holy Qur'an, God said:

> 'Say, (O Prophet) O my Lord, increase me in knowledge' (Qur'an; 20:114).[15]

Also,

> 'Read! And thy Lord is Most Bountiful; He Who taught the use of the pen, Taught man that which he did not know' (96:3–5).[16]

8.4.6 Neglect: A Phenomenological Perspective

> 'Does man think that he will be left neglected [without being punished or rewarded for the obligatory duties enjoined by his Lord (Allah) on him]?' (Al-Qiyama: 75–36).[17]

Also,

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[15] The Qur'an, (1989). Surah Taha, (20/114). (Arabic version, Translated by Yusuf Ali) Saudi Arabia: The Holy Qur'an Complex in Madinah.

[16] The Qur'an, (1989). Surah Al-Alaq, (96:3–5).(Arabic version, Translated by Yusuf Ali) Saudi Arabia: The Holy Qur'an Complex in Madinah.

[17] The Qur'an, (1989). Surah Al-Qiyama, (75/36). (Arabic version, Translated by Yusuf Ali) Saudi Arabia: The Holy Qur'an Complex in Madinah.

'When Joseph attained his full manhood, We gave him power and

knowledge: thus do We reward those who do right' (Yousuf: 12–

22).[18]

The nursing profession, above all else, is a caring profession. It is a valid and

noble career for people within a caring society. It does not discriminate by gender,

nationality or religion. Nurses work to universally serve everyone in their society.

The caring offered by nurses, whether they are male or female, is given because they

are caring individuals providing a necessary service in a caring society. Boykin and

Schoenhofer (2001, p. 11) state 'the unique focus of nursing is posited as nurturing

persons living, caring and growing in caring'. Now, having defined nursing, any

researcher cannot help but wonder why the profession of nursing is characterised by

neglect. Saudi nurses have expectations of their profession. If the nursing profession

is unable to at least make progress towards meeting these, then the very idea of the

profession becomes questionable (Donaldson & Crowley, 1978).

There has been nursing research that looks at the health care profession in

Saudi Arabia, but it does so predominantly from a mechanistic, broadly systemic and

objectivist viewpoint, rather than a phenomenological one. Jannadi, Alshammari,

Khan and Hussain (2008, p. 49) for example, state, 'to date the public healthcare

system has been able to cater for the healthcare needs in terms of both human and

financial resources'. On the surface, this may appear to be the case. However, the

phenomenological research conducted for this thesis indicates otherwise.

Phenomenology approaches research by looking into the lived experiences of

those being interviewed and in this way has uncovered that Saudi nurses themselves

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[18] The Qur'an, (1989). Surah Yousuf, (12/22). (Arabic version, Translated by Yusuf Ali) Saudi

Arabia: The Holy Qur'an Complex in Madinah.

view neglect as a serious problem. Through this style of research, it is possible to know and understand that 'an increasing emphasis on the training of [Saudi] healthcare managers' (Jannadi, Alshammari, Khan & Hussain, 2008), although a step in the right direction, is not enough if it does not take into consideration the sociocultural issues in relation to gender and religion that have been raised in this research.

There has been and still is neglect in the use of Saudi culture and Saudi language. Saudi culture is not respected when it comes to the lived experiences of Saudi nurses—there needs to be consideration for mixing and for Saudi female nurses needing to abide by customs in their families—and Arabic needs to be used more in Saudi nursing.

When the Holy Qur'an speaks about identity, it talks about uniqueness. When it speaks about uniqueness, it speaks about the self. This is where the Holy Qur'an connects with phenomenology and where phenomenology focuses on neglect.

Despite the problems in Saudi nursing, the skills and knowledge Saudi nurses have learned and developed should not be overlooked. In their professional positions, Saudi nurses have needed to be creative. The creativity Saudi nurses have needed to utilise to care for and improve the health and lives of Saudi people has been essential to their work. However, now it is necessary that Saudi nurses have more freedom and more control in nursing, as can be found in some other countries, particularly Western ones with a democratic philosophy. The ideal of phenomenology from Husserl's viewpoint concerns consciousness and intentionality. Those of us from the Muslim world have much to learn from our contemporaries in other developed countries.

8.5 A Solar System Analogy for the State of Saudi Nursing

Nursing in Saudi Arabia is in disarray. With the key words describing the essence of this disarray being disempowerment and neglect, Saudi nursing and its themes remind can be depicted as a model of our Solar System.
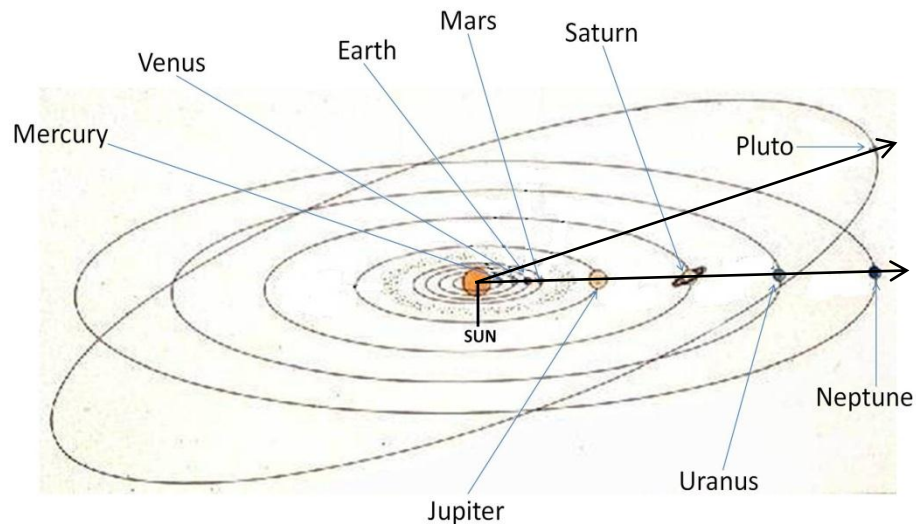
Figure 8.8. The Solar System.

Figure 8.8 shows the Sun, the power source of life in the solar system. The planets are components of the solar system and they rely on the power of the sun—they are empowered by the sun. The further they are from the sun, the less power they receive; they become isolated and relatively disempowered, compared to planets like Mars and Earth. The sun is the power source that all the planets must have to be viable. As well, the planets each revolve around the sun in elliptical orbits. These orbits cause the seasons and create colder or warmer environments for the planets.

This system parallels the Saudi nursing system. However, the Saudi nursing system, with disempowerment and neglect as its essence, is dysfunctional. Figure 8.9 illustrates this system.
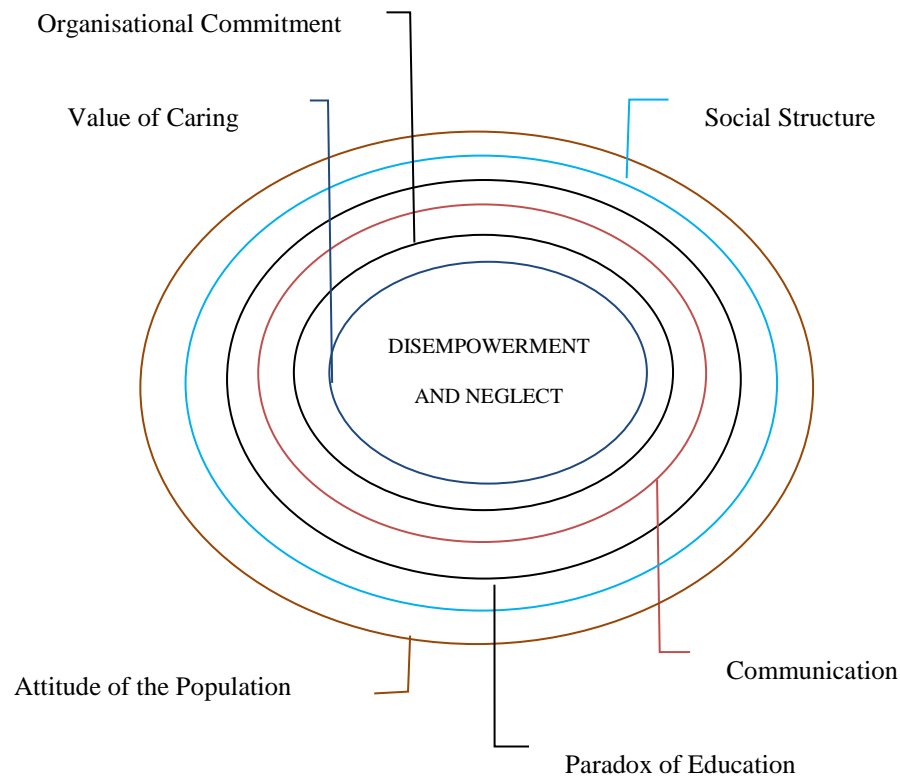
Figure 8.9. A thematic model of the saudi nursing system.

Figure 8.9 does not have power at its centre. Instead there is disempowerment and neglect. The planets revolving around the centre are now 'planetary themes'— themes that grew out of the interviews with Saudi nurses. The planetary themes are Organisational Commitment, Communication, Education, Social Structure, Attitude of the Population and the Value of Caring. The elliptical orbits of the planetary themes equate to the circular connection of the nursing themes, as detailed in the figure. Note that as planetary themes, these themes are all expressed as neutral themes, neither negative nor positive. However, each becomes negative because the centre of the diagram is not an empowering power source like the sun, but rather disempowerment and neglect. It is worth noting that the Value of Caring and Organisational Commitment are positioned closer to the 'sun' of Disempowerment and Neglect. This is because they are perhaps more significant than the other themes

and play a greater role in determining the other themes. There is a case for positioning neglect away from the 'sun' as another theme.

If these themes were the planets of the earlier diagram (see Figure 8.8), they would all be like Pluto, far away from any empowering source. In this system (Figure 8.9), gravity would also be erratic with a power source of disempowerment. The planetary themes of Communication, Education and Organisational Commitment would drift continually further away in their neglect. The planetary themes of Caring, the Attitude of the Population and Social Structure would have their problems too, perhaps colliding with each other in their lack of power and confusion. The seasons would all be cold and icy and the climate predictions always poor.

In a planetary themes model like this, the ideal is for the centre of the model to contain a source of power that maintains the orbits of the planetary themes, controls their operation by supplying their needs and keeps them stable within gravitational fields. The planetary themes need to move freely in a stable manner as they revolve around their power. Their elliptical orbits would still cause seasons— sometimes there would be more positive or more negative elements to the themes— but generally they would be stable and flourishing planetary themes.

This is not the case with Saudi nursing. As the diagram suggests, the system is in serious need of repair.

8.6 Conclusion

The nursing profession in Saudi Arabia is facing a workforce crisis. The experience of the participants in this research provides an insight into the life of Saudi nurses. The research indicates controlling influences upon the actions of Saudi

nurses. These influences are unrelenting and do not support Saudi nurses in their profession.

Disempowerment and neglect currently challenge Saudi nurses. Continuing perceptions of nursing as a simple, menial profession (see Prologue) make it difficult to attract young Saudi nurses, both male and female, and the problems in nursing make it hard to keep nurses in the profession. The process of recruitment and retention is failing. Both Saudi men and women are being attracted to alternative career opportunities with better remuneration and other rewards. How can it be any different when nursing education is seen as inadequate and administration is seen as lacking knowledge and expertise and consideration for the interests of nurses?

All aspects of the Saudi nursing profession require change for nursing to achieve its mission of providing care. Structuring a framework for a new system of nursing in Saudi Arabia requires a positive outlook as well as acknowledgement of the problems. If the shortcomings of nursing are not acknowledged by all involved in nursing, how can change begin?

Chapter 9: Conclusion

9.1 Introduction

The meaning of being a Saudi nurse has been explored from a phenomenological viewpoint and summarised in the preceding chapter. A careful examination of the transcripts of the subject interviews has revealed the nurses' perceived needs, based on their understanding of their development and practice. The significance of those needs provides a direction for change.

This change must be away from disempowerment and neglect, which unfortunately go hand in hand with irritation, frustration and depression. The neglect of nurses is passed on to patients and they too are neglected. The patients are not attended to by understanding, caring Saudi nurses. Instead they are cared for by stressed, overworked, disappointed nurses, who are itching to leave their profession.

These twin essences of neglect and disempowerment need to be carefully considered, as they impact significantly on efforts to improve working conditions for nurses. This affects the retention of nurses currently working and makes it difficult to attract newcomers to the profession (Greco, Laschinger & Wong, 2006). The findings highlight the need for nursing to address the essences found in this research through a number of approaches. In this chapter, this phenomenological research offers some suggestions for how neglect and disempowerment can be addressed. Based on the words of the participants in this research, the next section will revisit the key findings of the lived experiences of Saudi nurses to propose strategies for developing the nursing profession in Saudi Arabia.

9.2 Implications of the Research Findings

The driving force of the current research has been the phenomena of the lived experience. This has provided the data needed to assess the requirements of Saudi nurses and has provided direction for nursing reform. The workforce must be empowered to eradicate neglect. Trofino (1995, p. 42) states:

> 'Accelerated change and increasing complexity require an empowered workforce. Empowerment may be defined as self-direction, allowing people to take responsibility and authority for decisions that affect them.'

The findings of this research suggest that the most important changes to be made involve:

- Misunderstanding of the Islamic viewpoint;

- The foreign influence on Saudi nursing;

- The communication between nursing organisations and their nurses;

- The retention of Saudi nurses;

- Education and training;

- The need for research; and

- A need for transformational leadership.

9.3 Strategies and Recommendations

9.3.1 Misunderstanding the Islamic Viewpoint

> 'I had no information or background about nursing' (Khalid).

> 'I don't think that society is aware of the real role of the Saudi nurse' (Reem).

Faten went so far as to say that because of society's lack of support and misunderstanding of nursing, the situation for nurses was 'unacceptable'. All the nurses agreed that the prevailing Islamic viewpoint misunderstood nursing. Faten, Sarah and Waleed are just three of the nurses interviewed who said people do not understand the role of the nurse. The lived experience of Saudi nurses needs to be seen in the context of the country's unique history. This history is based on Islam which means Saudi nurses are committed to nursing, but they also hold responsibility as Muslims.

Saudi nurses have to deal with being misunderstood. The Saudi nation wants good health care, yet they criticise their nurses. Why? Because men and women sometimes work in the same environment? Because they sometimes give nursing care to the opposite gender? These things rarely happen. When they do happen, it is in the best interests of the health of the patients. What people sometimes forget is that mixing also happens because the current structure of the nursing system requires it in some instances. So how can Saudi's criticise Saudi nurses for mixing when that same society has created a system that makes mixing necessary?

As supported by the interviews, there are many nurses who do not want to be involved in mixing at all. Almost all Saudi nurses wanted to do what is right according to their religion and their accounts contained images of nursing as a humanitarian practice involving both genders. Unfortunately, the results of this research have revealed that the development of nursing in Saudi Arabia has been inconsistent with prevailing cultural beliefs about caring and gender. A Saudi model of modern nursing is missing, or, if it does exist, it is deficient. The current model of nursing has not been embedded in the Saudi culture or the Islamic perception of caring. The need to create a Saudi model of the nursing profession by adapting the principle of nursing theory to the culture of Saudis is essential. However, this cannot

occur without acceptance from the prevailing Muslim religion. Muslim clergy should be encouraged to speak on behalf of the goodness of the nursing profession.

Nursing authorities need to seek statements supporting their cause for acceptance in the eyes of the community. Perhaps nursing organisations and scholars in Saudi Arabia can get together, at the request of the King, and formulate a statement about nursing issues—for example, a statement or advertisement in the media praising Saudi nurses and the nature of the work that they do. If this happened, I would be confident that the statement would promote nursing and help alleviate some of the gender-related problems and cultural issues involving the working conditions of Saudi female nurses.

Saudis must come to understand the Islamic view of nursing and see that Islam does not condemn nursing. Indeed, Muslim women participated significantly in their society as nurses during the time of the prophets of Islam and throughout history the position of women in Islamic culture has been highly regarded (Doumato, 1999; Haddad, 1984; Sidani, 2005). Unfortunately, current commonly held social viewpoints, which many Saudis interpret as Islamic traditions, deny women and nursing the respect the nursing profession deserved. Many Saudi nursing problems stem from this misunderstanding (on the part of both the general public and the nursing bodies) of the relationship between Islam and nursing. If Saudi nurses were better educated about the cultural and religious viewpoints on nursing, then they could work together—with nursing bodies—to educate their patients and the wider public. This would lead to better conditions as understanding improves. It would also lead to more Saudis being interested in nursing and training to be nurses. Of course, the cultural and religious viewpoints on nursing are not clear. Saudi nurses cannot be more understanding about what nursing is and how it relates to Islam if the Muslim view on nursing is not clear.

When the public sees the real value of nursing they will become more understanding and supportive. Then, we will see nursing organisations that truly work for both nurses and the public to make nursing a caring profession. With this goal in mind, the following recommendations are offered:

- Seek statements from Muslim clergy that promote nursing;

- Educate the public to see that mixing is only a side issue—the real issue is the need for professional nursing; and

- Create a Saudi model of the nursing profession by adapting the principle of nursing theory to the culture of Saudis.

9.3.2 Foreign Influence of Saudi Nursing is Significant and Conflicts with Islamic Culture

'There is a lack of understanding between the foreign nurse and the Saudi patient' (Norah).

'In most cases, the boss is a foreigner and he does not observe conditions and circumstances related to Saudi nurses' (Waleed).

Nursing is a worldwide institution and the system of nursing is something that all countries have in common. However, the foundations upon which nursing is based are not native to Saudi—they have been imported from abroad. Consequently, the language of nursing in Saudi is English, not Arabic and the functioning of the nursing system is imported, rather than designed for the culture. This translates to an extensive overseas influence on nursing in our nation. This cannot be ignored by our country, for there are many differences between a Western country and Saudi Arabia.

Islamic thought conforms to some of the most important characteristics of Western democracy, but of course there are differences. As Muslims, Saudi nurses have a right to appoint their leader, hold them accountable and, when need be, remove them from power in a nursing organisation. Islam does not, however, empower the system of management with the right to neglect and disempower Saudi nurses. And in Islam, legislation is the right of God alone, and religion must be essential in deciding the validity of any new rule (El-Affendi, 1999; Voig, 2005). Lewis (2002, cited by Voig, 2005, p. 69) states, 'in the Muslim perception, there is no human legislative power, and there is only one law for the believers—the Holy Law of God'.

In a Western democratic system legislators have the function of passing formal legislation that facilitates centralised cooperation, which is believed to be welfare enhancing (Keohane, Macedo & Moravcsik, 2009). Therefore, it seems necessary to endow legislators with the competence to pass fresh legislation. However, Islam has had extraordinary difficulties with this notion of legislation (El-Affendi, 1999; Voig, 2005).

Traditional Islamic concepts like consultation (*shura*) between the ruler and the ruled, society consensus (*ijma*), public or community interest (*maslaha*), and scriptural based opinion (*ijtihad*), are mechanisms that can be used to support forms of administration with systems of checks and balances among the executive, legislative and judiciary branches (Voig, 2005). However, rulers of authoritarian societies tend to ignore, discourage or suppress democratic organisation institutions (Inglehart & Welzel, 2007; The Deen Show, 2010). Islam has its own ideas about democracy—and these are very relevant to nursing systems. In Saudi Arabia, a democratic system must first be understood within the framework of Islamic

thought, as the fundamental beliefs of Islam play an essential role in any system of authority (Abu-Tapanjeh, 2009; Kamali, 1991; Khadduri, 1984; Voig, 2005).

In Islam, by no means can any system of power neglect, absolve or interrupt the authority of religion. This is an example of the pure monotheistic nature of Islam, in which all rights due to God are rendered to Him alone and no one else. According to Voig (2005, p. 68), 'when autocrats seize power and rule arbitrarily rather than under general rules, their rule is likely to be interpreted as fate'. Many observers have stressed the 'Muslims' fatalism', as Islam considers any rule to be arbitrary if it is not based on religious authority (Abu-Tapanjeh, 2009; Voig, 2005).

Gellner (1994), cited by Voig (2005, p. 69), states that in Islamic understanding 'legislation was distinct from the executive because it had been pre-empted by the deity, and religion itself was above all the Constitutional Law of society'. Therefore, to achieve empowerment in any aspect of Islamic society—such as in nursing—it must be under the guidance of the religion of Islam.

The notion of worship in Islam is not restricted to mere rituals, but includes deeds of obedience and goodness. In other words, the concept of religion extends to all avenues of life in the world (Khadduri, 1984). In any push to improve nursing, these points need to be remembered.

The influence of expatriates on Saudi nursing is rarely compatible with the culture of Saudi Arabia. All aspects of Saudi nursing not based on Islamic principles and considerations for Saudi culture must be challenged and examined. Nursing bodies, with the support of the government, need to push for this. This includes reassessing nurses' working conditions and the language used in education and nursing practice. Based on this, the following recommendations are offered:

- Move away from models of leadership involving expatriates; and

- Challenge and examine all aspects of Saudi nursing not based on Islamic principles and considerate of Saudi culture.

9.3.3 Nursing Organisations Must be Sensitive to the Needs of Nurses

'The nursing department is just a name for nothing. This department does not play any role in developing the Saudi nurse' (Ahmad).

'We need encouragement' (Imtinan).

Nursing organisations in Saudi Arabia must make fundamental changes to their nursing workforces. These changes must effect education, training, management, professional development and opportunities for career advancement. The status of nursing in Saudi Arabia should be enhanced to make it a worthwhile career (Almalki, FitzGerald & Clark, 2011). The required changes will strengthen the quality of care provided and restore the professional identities of Saudi nurses.

However, in making changes, nurses should be listened to and seen as professionals with rights that should be respected. After consultation, a charter should be written up detailing the rights of nurses. In implementing the points on the charter, nurses should be heard and their needs and opinions made a priority. This, of course, involves taking into account the cultural needs of Saudi nurses.

To promote the value of caring, there must be encouragement to help both sides—nurses and administration—work together to reach practical agreement. Hofmann (2001, p. 369) points out that when facing the challenges of modern health care, 'the focus of concern should be to resolve the resolvable paradoxes, to acknowledge the objections and to learn to live with them'. To address the points above, the following recommendations are made:

- Guidelines detailing nurses' rights should be developed so that all nurses are treated fairly and equally;

- Nursing organisations must make a thorough examination of nursing in Saudi Arabia and make fundamental changes to their nursing workforces;

- Campaigns should be initiated to enhance the status of nursing in the Kingdom; and

- Nursing bodies must be instructed in how to be sensitive to the cultural background of Saudi nurses and nursing in Saudi Arabia.

9.3.4 Encouraging Saudi Nurses to Return to Nursing and Retention of Saudi Nurses

'If I had found support, I would still be a nurse' (Ahmad).

'Yes, nurses need our attention. Reduce the working hours. The working hours of nurses is too long. The female Saudi nurse spends most of her time in hospitals. This issue conflicts with the role of the women in their homes. It causes female nurses to neglect their homes, their husbands and their children … Yes, most Saudi nurses leave because of the difficulties they encounter in their practice' (Zainab).

Nursing recruitment will become easier and more Saudi nurses will stay in nursing when job satisfaction improves. This means improving the salaries and conditions of nurses as well as promoting an understanding of nursing that allows nurses to be both good nurses and good Muslims.

Cultural issues relating to mixing and long work shifts must be addressed. A special strategy needs to be devised to bring Saudi nurses—who have typically been

neglected—back into the profession. The strategy should include good quality return to practice programmes as well as attractive financial incentives. These should be offered throughout the country, not just in one region, in consideration of the Saudi females in particular who find it difficult to travel. Nurses who have left the profession and are now willing to return should be offered a programme that is flexible and which satisfies their needs. The programme could be run by Saudi nurses and certificates of attendance could be given to those who participate. A Saudi family-life policy should be adopted to attract nurses back into nursing work. One option is to offer shorter or flexible shifts.

The education of the public is also very important. When the public sees the real value of nursing, they will become more understanding and supportive. More money needs to be invested in nursing so that a greater number of qualified and capable administrators can be hired to oversee nursing in Saudi Arabia. In this way, we will see nursing organisations that truly work for both nurses and the public, allowing nursing in Saudi Arabic to realise its true nature as a caring profession.

At this time, nursing recruitment will become easier. With increased job satisfaction, nursing will increase the number of Saudis in nursing, reducing reliance on overseas staff. To this end, the following recommendations are made:

- Develop strategies to bring retired Saudi nurses back into the profession;

- Increase job satisfaction by raising salaries and improving work conditions;

- Develop a Saudi approach to nursing which considers Islamic cultural needs;

- Invest more money in nursing; and

- Initiate a public awareness programme to educate the public about Saudi nursing, to increase understanding of the invaluable roles nurses have and increase their prestige in the eyes of society.

9.3.5 Education and Training

'… education is ignored … The policy of education is very bad and needs to be reconsidered … Regarding the practical training we were given, there were no trained supervisors' (Ahmad).

'My course of study was not good enough' (Ali).

To train nurses properly we must develop a better education system. This clearly involves having a greater emphasis on trained educators and the involvement of Saudis. It also requires educational management that is not run with an emphasis on profit. For nursing in Saudi Arabia to continue to develop, it is not just formal education at educational institutions that Saudi nurses require, they also require cooperation between the universities and the health colleges and institutes throughout Saudi Arabia. Further, this cooperation should extend to the medical profession as well as allied health professions, so that nursing knowledge can be shared and policies of best practice promoted.

Nursing organisations in Saudi Arabia have an obligation to have well-trained and well-educated nursing staff for the Saudi patients. The government needs to invest in continual development for nurses within the nursing profession. Nursing management needs to sustain this by offering support in the way of courses and experience in other workplaces as part of the nurses' professional development (Gul, Paul & Olson, 2009; Kuokkanen & Leino-Kilpi, 2000; Skar, 2010).

At the same time, nurses need to be held more accountable for their performance. Centralised regulation boards need to be put into place to monitor nurses' education and practice. These could, for example, undertake randomly conducted nursing audits or call upon nurses at regular intervals (every year or two) to demonstrate evidence of learning since their last registration renewal.

The standardisation of Saudi nursing education and post registration courses needs to be made a priority throughout Saudi Arabia. Saudi nurses, in particular those who are registered, need to be given the necessary training and preparation to take on new roles. Therefore, nursing tasks need to be standardised throughout the Saudi regions so that a Saudi nurse applying for a different nursing position or role in another region can expect the same standard to be required of them and work with the same set of competencies to perform their tasks effectively.

A new model of nurse education needs to emerge with an emphasis on improving and developing practical skills earlier. This may mean a nursing programme with a curriculum that is consistent with the standards of proficiency for pre-registration nursing education recommended by NMC (2004) (50 per cent theoretical and 50 per cent practical). Practical placement periods for Saudi student nurses should be longer. Saudi clinical tutors should be employed to teach, clinically supervise and assess the student nurse on a day to day basis in a clinical setting. For this to be effective, competency-based programmes need to be established and used throughout the country.

Saudi nurses need to be trained in culture-specific health care and be culturally competent. It is reasonable to assume we cannot separate culture from nursing in Saudi Arabia. Luna (1998) argues that culturally competent health care is a challenge for nursing in Saudi Arabia. Cultural competence means having the beliefs, knowledge and skills necessary to work effectively with individuals different

from one's self. It includes all forms of difference and deals positively with matters of social justice (Krentzman & Townsend, 2008; Leininger, 2002a). Competence as a concept often refers to the effective functioning of individuals in society. The concept of competence is used to refer to the ability of individuals and organisations to function within the context of their cultural beliefs. However:

> 'a health provider cannot be culturally 'competent' in a second culture unless he or she grew up in it or is at least fluent in the language' (Meleis & Lipson, 2004, p. 70).

The Saudi nurse has to adapt all the time in the face of many obstacles. Those who stay in nursing grow stronger. However, even these nurses are leaving because of the difficult conditions. In improving nursing conditions in Saudi Arabia, there is a lot of talk about educating nurses so that they can be more effective workers. However, in many ways, it is more important to educate those who have responsibility over the working conditions of nurses so that nurses can work within a framework that allows them to be better workers.

With this in mind, nursing organisations should build up libraries of professional literature regarding both practical and theoretical learning in nursing. Saudi nurses should be taught to seek further learning and recognise when extra learning in required. By maintaining and increasing their professional knowledge, Saudi nurses can advance professionally. This is particularly important because providing culturally specific and congruent care to a culturally diverse population is a growing professional challenge (Jeffreys, 2006). To face this challenge effectively, nursing administration needs to be culturally sensitive, which means that the administration needs to feature a greater representation of Saudis.

According to Jeffreys (2006, p. 24), for health care education and health care professionals, the challenge is to provide educational opportunities to enhance the cultural competency of health care professionals so that quality outcome indicators, such as enhanced client satisfaction and positive health outcomes, may be achieved. Jeffreys adds that 'confidence—clearly connected to a nurse's job satisfaction—is a vital component in the process of learning cultural competence' (2006, p. 24).

The findings of this research confirm that there is a gap between health needs and health provision, with the current curriculum for nurse training failing both nurses and patients. The experiences of nurses have provided them insight into the weaknesses of the education systems. However, too few Saudi nurses have the level of involvement in this system required to bring about the changes they all want. A central nursing strategy is needed, alongside a vision for nursing in Saudi Arabia. Saudi nurses need a clear career pathway from nurse entry through to senior levels, including in clinical practice, education and management, with recognition for nurses who are educated to Masters or PhD level.

It is important that Saudi nurses see a career ahead of them that offers opportunities such as further education and training and that they have more involvement in the education and training of new nurses. It should be Saudi nurses, who know the needs of nursing in Saudi Arabia, who have control of training. Therefore, it is important to have Saudi nurses involved in the on-the-job training and further training of Saudi nurses.

These strategies do work. In the UK, the National Health Service (NHS) (2001) report states that due to similar reforms, there are now 10,000 more nurses working in the NHS than there were in 1997. Nursing organisations in Saudi Arabia must learn from countries like the UK. They must address the education issues of

Saudi nurses and recognise that each Saudi nurse requires training in practical skills. There must be a commitment to funding ongoing education and training.

There is more that this research has found that is needed to improve the education and training of Saudi nurses. There is a need for more nursing institutions and universities that teach nursing in Arabic. These education service providers need to be spread throughout the Kingdom. As well as learning nursing in Arabic, all Saudi nurses should learn English to a high level. Courses should be introduced to improve the English skills of Saudi nurses. Nurses who train in HIs, like those in health colleges, should be taught in English. In view of the above, the following recommendations are offered:

- More extensive and relevant training;

- The introduction of more courses to improve nursing skills;

- The standardisation of nursing tasks;

- The establishment of competency-based nursing programmes;

- Cultural sensitivity and competence should be taught to Saudi nurses;

- All Saudi nurses should learn English to a high level. Courses should be introduced to improve the English skills of Saudi nurses. Nurses who train in HIs, like those in health colleges, should be taught in English;

- Better qualified trainers and supervisors need to be sought after and employed; and

- There needs to be more nursing institutions and universities that teach nursing in Arabic and they need to be spread throughout the Kingdom.

9.3.6 The Need for Nursing Research

'There is no development or lectures and there are no programmes

which nurses with their different nationalities can benefit from …

First of all, we must focus on education' (Ali).

Only through research can nursing as a profession modernise and share its activities among all nurses (Castles, 1987; Huber, 2006). Nurses throughout the world, through nursing research and education, have created and voiced ideals for nursing, and on an international level, nurses have taken responsibility for their own profession. This has not happened as it should and needs to in Saudi nursing. Our nursing profession has continued to rely on multinational approaches—the Saudi nurse's education, practice and management are all based on different languages and resources—which broadly ignore the inherited nature of the Saudi nurse's culture and the context of their nursing.

Saudi nurses will find it difficult to contribute to the body of their nursing knowledge without knowing and understanding the processes involved in nursing research. The fact that almost all Saudi nurses graduated from HIs and/or health colleges, and not universities, means they lack the skills required for research—there simply were no nursing research subjects in the curricula of nursing Education.

In addition to the lack of knowledge and experience about nursing research among Saudi nurses, in Saudi Arabia there is also a lack of research support services (Tumulty, 2001a) because nursing organisations do not consider research a part of nursing. Saudi nurses might lack the self-confidence and experience to engage in research projects, but ignoring the importance of nursing research is ignoring the lived experiences of being Saudi nurses. The knowledge and experience of nurses

needs to be considered without excuse (Billeter-Koponen & Freden, 2005; Joel, 2006).

Research is a purposeful activity utilised to acquire knowledge: the knowledge that can only be acquired through a systematic process (Tilley, 2004). Research is defined here as the systematic and rigorous process of inquiry that aims to provide objective knowledge of phenomena under investigation and ultimately contribute to a scientific body of knowledge (Bowling, 2002).

Theoretically, the aim of nursing research is to investigate, evaluate, describe and interpret the concepts and theories that involve the principles upon which nursing knowledge is grounded. However, there are barriers to nursing research. One is the organisational culture (Fink, Thompson & Bonnes, 2005). Montgomery, Eddy and Jackson (2001, p. 125) list other factors such as 'lack of knowledge among nurses of the research process and the inability to understand research reports'. Other researchers include negative perceptions and attitudes among nurses and a lack of organisational support, time, resources and confidence (Harne-Britner & Schafer, 2009; Rogers, 2009). Bostrom, Malnight, MacDougall and Hargis (1989) found that nurses' involvement in clinical research was dependent upon the attitudes they held towards research.

Providing nursing knowledge based on the best evidence is a priority for nursing organisations across KSA. According to Harne-Britner and Schafer (2009, p. 305), 'the value and importance of nursing research for practice can be an effective approach in changing the culture'. Likewise, Karkos and Peters (2006) state that supporting nurses to use research can assist in developing and advancing nursing practice and enhancing the quality and efficiency of care provided.

If practicing nurses have knowledge of research, the nurses' self-efficacy towards research increases (Harne-Britner & Schafer, 2009; Solomon, Albert, Sun,

Bowers & Molnar, 2011). Nurses become more positive about implementing change based on research findings and have increased confidence in practicing nursing activities based on evidence (Camiah, 1997; Fink et al., 2005; Milne, Krishnasamy & Johnston, 2007). Thompson, Estabrooks and Degner (2006) report that there is a need to provide nurses with the necessary skills and knowledge to establish, assess and implement research knowledge. In research conducted by Camiah (1997), the participants felt more positive about using research in practice after applying strategies identified in the research findings.

Nursing as a concept of caring has been broadly supported by the scientific methods of modern research, and nursing researchers generally acknowledge the remarkable influence of the scientific method of research, which has helped provide the underpinning infrastructure for good decisions by policy makers to improve clinical nursing practice and education (Heath, 2002).

Research, as a scientific process, by means of its intrinsic competence to explain and predict the phenomena of interest, improves a practice discipline's capacity to integrate nursing research into practice and guide interventions (Solomon et al., 2011). According to Rogers (2009), nursing management throughout the world is searching for innovative means to bring research into practice in order to improve the quality, effectiveness and safety of health care workers. Given the challenge of integrating nursing research into practice, Snyder (1992, as cited in Sharon & Carol, 1995, p. 11) stated:

> 'When nurses in clinical areas, legislators, and policy makers can
> see the impact that nursing interventions can make on patient
> outcomes and costs, nursing will have taken a giant stride forward
> in being recognised as a practice discipline that uses a scientific
> knowledge base to make a difference in patient outcomes.'

To increase the use of research in Saudi nursing, the following recommendations are made:

- In their training, teach nurses the processes involved in nursing research;

- Provide more research support services;

- Provide nurses with positive experiences of the research process; and

- Provide more funding for Saudi nursing.

9.3.7 Transformational Leadership and Empowerment: New Possibilities

'… nursing management does not work to improve the Saudi nurse's performance, and makes us feel valueless in helping our society' (Imtinan).

'We need nursing management to give us confidence and motivation and to allow us to improve our situation' (Khadijah).

'We as nurses need support and recognition in order to improve our outcome' (Sarah).

The following sections contain the strategies and recommendation for changes to Saudi nursing. They are in direct response to the need to alleviate the neglect and disempowerment in Saudi nursing. However, before making recommendations for change it is important to consider ways in which change may be effected. According to Trofino (1995, p. 43) 'the catalyst for the transformation will be leadership'. In the past the traditional hierarchy within the hospital system has meant that nurses had little opportunity to gain confidence in decision making and skills in assertiveness and negotiating. According to Gordon (as cited in

Armstrong, 2004, p. 18) nurses have been invisible toilers in the health system. She urges nursing leaders to empower the profession so that they can bring about change in the health system.

Change both produces and requires an empowered workforce (Nehmeh, 2009 Latham, Hogan & Ringl, 2008). According to Kelly (1999, p. 420):

> 'Empowerment is the process by which we facilitate the
> participation of others in decision making and taking action within
> an environment where there is an equitable distribution of power.'

Trofino (1995, p. 42) states, 'empowerment may be defined as self-direction' and this self-direction influences the intentional aspect of Saudi nurses to take responsibility and authority for decisions that affect their professional development. Empowerment allows people to collaborate freely and contribute towards decision making. Empowerment is associated with the commitment nurses make to be involved in their practice and the decisions that derive from that commitment (O'Rourke & Davidson, 2004).

There is a need for transformational leadership in empowering the workforce and eliminating neglect, with the main role of nurse leaders being to empower others and nurture new leaders for the future (Al-Hosis, 2010; Trofino, 1995). A critical feature of successful teams, especially in knowledge-based enterprises, is that they are invested with a significant degree of empowerment or decision-making authority (Kelly, 1999; O'Rourke & Davidson, 2004). This leads to the empowerment of their staff. Consequently, employee empowerment changes the managers' mind-set and leaves them with more time to engage in broad-based thinking, visioning and nurturing (Kelly, 1999). Trofino (1995) describes a programme in the US in which

all nurses are given a basic management course in their first year of employment. This kind of in-service education for Saudi nurses would be invaluable.

The kinds of leaders who empower and encourage others at all levels to be involved in decision making are recognised to be transformational leaders (Marquis & Huston, 2008; Jooste, 2004). Transformational leaders have vision for the future and are able to inspire others to share their vision so that they may move forward together to achieve their goals (Manojlovich, 2007; Trofino, 1995). Five main principles of transformational leadership are set out by Jooste (2004, p. 221). These are: inspiring a shared vision, enabling others to act, challenging the process, modelling the way and encouraging the heart. Jooste (2004) believes that nurses in the future will require vision, knowledge and strategic thinking abilities, management and negotiation skills and confidence.

Communication is another important factor in bringing about change. Successful change will only occur if those who will be affected thoroughly understand the change and its effects. When information and decision making are shared, all levels of staff will feel involved and know that they have played a valuable role (Kelly, 1999; O'Rourke & Davidson, 2004).

The organisational structure that is considered most appropriate for the twenty-first century is that of shared governance. Shared governance empowers people within an organisation, giving nurses increased authority and control over nursing practice (Marquis & Huston, 2008). Marquis and Huston (2008) indicate that this model improves nurses' perceptions of their job and results in greater work satisfaction, retention and positive patient outcomes.

A study by Campbell, Fowles and Weber (2004) suggests that the more consultation between supervisors and subordinates, and the greater the participation of nurses in all levels of decision making and task definition, the higher the job

satisfaction. Transformational leaders promote what is best for all concerned—patients, leaders and followers. Too often, power involves coercion or control; leadership does not (Barker, 1990). Trofino (1995, p. 46) states that, 'nurses must participate as activists in the shaping of health care policy, and in the political and organisational decisions surrounding its implementation, outcomes and rewards'. Many recommendations come out of placing an emphasis on transformational leadership. These include:

- Train transformational leaders;

- Provide courses to teach nurses and nurse leaders about the processes of change and how to empower others; and

- Seek out and recruit transformational leadership that will empower others in the nursing profession.

9.4 Areas for Future Research

The aim of this research has been to uncover the meaning of the lived experiences of Saudi nurses and address their needs. Through phenomenological research methods, this has been done. One issue that stems from this phenomenological study is that nursing organisations must become more involved in phenomenological research, through which nurses can see, hear and feel each other's experiences and views.

Saudi nurses have been found to be disempowered and neglected. It was shown that their profession carries a stigma that needs to be changed. Overall, results have shown that continued research is necessary to assess factors that have placed the Saudi nursing workforce in crisis. This research needs to include qualitative studies that further explore improving nursing performance in the workplace, without contradicting the social life of Saudi nurses.

How does a nursing organisation move from disempowerment to empowerment? It would be helpful to explore the needed changes in Saudi nursing according to key concepts (see Table 9.1). Further phenomenological research could examine these concepts. As more and more Saudi nurses are interviewed and more data are gathered, a larger picture will emerge. Table 9.1 presents a list of concepts that indicate possible directions for further research.

Table 9.1

Key Research Concepts and their Related Key Factors

Concepts	Key factors
Opportunity and Advancement	Opportunity for advancement requires involvement in activities beyond one's job description (Kanter, 1993). Understandable boundaries must be set up that will make Saudi nurses feel both comfortable and challenged (Blanchard et al., 1999).
Access	Access to resources as needed by the employee (Kanter, 1993). Access to information about all facets of the organisation (Campbell et al., 2004; Kanter, 1993).
Information	Information must be shared by managers liberally with employees to help create a sense of ownership (Blanchard et al., 1999).
Decision Making and Support	Access to support for one's job responsibilities and decision making (Kanter, 1993). Managers must develop teams to replace the old hierarchical structure (Blanchard et al., 1999).
Resources	A workplace that has the requisite structures that promote empowerment (Manojlovich, 2007).
Belief	A psychological belief in one's ability to be empowered (Manojlovich, 2007).
Acknowledgement	Acknowledgement that there is power in the relationships and caring that nurses provide (Greco et al., 2006; Manojlovich, 2007).

The concepts outlined in Table 9.1 must be applied to nursing organisations and considered in reform and research. Alternatively, research could be based on any issues reflected in the lived experiences of nurses when their voices are heard.

9.5 Limitations of the Research

The limitations of this study are related to the small research population and limitations of qualitative methods. Having a larger research population may have uncovered new themes not considered by the research participants. In addition, due to cultural and religious limitations, a female interviewer was employed and, although experienced, she may not have been comfortable deconstructing some of the issues raised.

Cultural suspicion as to why anyone was asking such questions may have prevented some participants exploring all their nursing experiences. This is because Saudi nurses are research naïve and do not understand the personal protections that exist. Access to potential participants was limited as a consequence of suspicion as to who was going to read the thesis and whether participants would be held to account for what they said.

Another significant limitation involves the issues surrounding translation and interpretation from one language to another. As discussed above, at times, no English word was available to reflect the intent of the Arabic word. Another issue is that qualitative research is not generalisable to a population. Phenomenology is only useful when little is known about a subject or an experience and it does not pretend to be anything more. However, the results from this phenomenological study provide a basis from which other research can be developed.

9.6 Conclusion

This study, which grew out of the perceived needs of Saudi nurses, is one of only a few research studies carried out on the lived experiences of Saudi nurses. As a nurse in KSA, I witnessed nursing first hand and saw many problems in the profession. I also saw that other nurses were not happy and, in fact, many nurses were leaving their profession. At a time when nursing in Saudi Arabia needed more Saudi nurses, not less, I decided it would be appropriate to undertake this research, with the primary aims being to uncover the experience of being a Saudi Nurse and the needs of Saudi nurses, based on their understandings of their development and practice as nurses.

This phenomenological research has revealed what Saudi nurses think, believe, need and desire, in relation to their profession. The opinions of the nurses interviewed has been consistent and has uncovered 'twin essences' in Saudi nursing—the nurses feel neglected and they feel disempowered.

Muslim beliefs and culture are being neglected because nursing is in the hands of expatriates. Expatriates, despite otherwise being good and capable nurses, do not understand—or have the motivation to understand—the impact of Islam on the actions of Saudi nurses and how this influences nurses' needs. Nurses and nursing administration from different cultural backgrounds dominate nursing in present day Saudi Arabia. Any development of Saudi nursing must consider this factor. However, so far, such consideration has been lacking.

A recurrent theme in the nurses' comments is that they feel neglected by nursing authorities and both want and need more influence over the nursing profession. Combined with this, the people of Saudi Arabia need to be educated to correct their ill-founded attitude towards nursing. They should be helped to

understand that nursing is not incompatible with Islam and that nurses should be encouraged and supported.

At a time when the government policy of Saudisation is prominent (with a special emphasis on Saudi nurses), it is even more important that the findings of this research have some influence in promoting better nursing conditions for our Saudi nurses. The attitude to Saudi nurses must change. It should be acknowledged that they need recognition and support if they are to continue in nursing and aid the implementation of Saudisation.

The purpose of Saudisation in nursing has been to open up more space in the nursing workforce for Saudi male and female nurses. The MOH has made many commitments to nursing—including the Saudisation of the nursing workforce. The number of health care facilities, including hospitals and health care centres, has increased dramatically in the last five years (MOH, 2008). However, public and the private hospitals remain predominately staffed with expatriate nurses. These expatriate employees benefit from higher salaries, better benefits and greater job security. Like many other countries in the region, the Saudi Arabian government has been aiming to privatise major public industries as a means of divesting itself of responsibility for being its citizens' main source of employment. However, so far, it has had limited success (Doumato,1999).

Findings from this research have revealed the hidden aspects of the reality of being a Saudi nurse. The essences of the research findings illuminate a relationship between Saudi nurses' identities as Muslims and the sociocultural factors described in previous chapters. Although previously unrecognised in Saudi nursing literature, there has been a growing body of research that reports on the relationship between identity and the unrewarding experiences of nurses. Findings from this research add

to the growing body of nursing knowledge that indicate that the identities of Saudi nurses being neglected.

Acknowledging the experience of Saudi nurses is an important practice for nursing and the nursing profession in Saudi Arabia. However, the lived experiences of the participants reveal that Saudi Arabian society still makes a distinction between being a nurse and being a Muslim. Overall, the cultural context, social interaction and organisational paradoxes contribute significantly to the low quality and status of Saudi nurses. Generally, the lack of social support stems from the lack of understanding of the Islamic point of view, while the paradox of organisational commitment is seen as a result of a lack of professional qualifications. All this affects the working conditions of nurses and the status of being a Saudi nurse.

The commitment of nursing organisations towards nursing education, practice and management is perceived by the participants as not reflecting the cultural values and principles of Islam. This is one factor that has led Saudi nurses to be unsatisfied in their profession, instead of experiencing nursing as a rewarding career. Nursing should be both seen as a rewarding career and experienced as one because nursing is about caring and caring is an ideal that all Muslims should have.

The participants in this research have a sense of powerlessness in the face of all their problems and they have a sense that no-one cares. The findings of this research offer Saudi nursing a new perspective on the influence of neglect and disempowerment on their profession and the meaning these concepts have for nursing culture in Saudi Arabia.

It is hoped that this research has helped to illuminate the problems faced by Saudi nurses and that it might serve as a prompt for others to undertake further research. Above all, it is the sincere wish of the researcher that this research will lead to changes in nursing for the better.

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Appendixes

MONASH University

Appendix A: Research Participant's Invitation (English)

Invitation to Participate in Research

Male and female Saudi nurses are invited.

I am interested in talking to Saudi nurses about their nursing practice and professional development. I am doing this as part of my doctoral studies in Australia at Monash University.

1   If you are a Saudi nurse who has been working for 5 years or more, I would like to invite you to participate in my research.

2   If you are female, you will be interviewed by a female research assistant.

If you are interested in participating, please contact me by either:

Mobile: ▓▓▓▓▓▓▓▓▓   or Email: ▓▓▓▓▓▓▓▓▓▓▓▓▓▓

I will be able to give you more information when you contact me.

Thank you

Fahad Alhetheli

PhD Candidate

Monash University

Australia

Appendix B: Research Participant's Invitation (Arabic Version)

MONASH University

دعوة للمشاركة في بحث علمي
لتمريض السعودي

إنني مهتم بالتحدث إلى التمريض السعودي حول عنوان البحث: مفاهيم وتجارب التمريض السعودي كجزء من دراستي لدكتوراه في التمريض لدى جامعة موناش في استراليا

هذا البحث العلمي يتم بالتعاون مع وزارة الصحة وإشراف إدارة التدريب والتعليم الطبي والبحوث العلمية بمنطقة القصيم.

هذه الدراسة خاصة بـ:

● الممرضين/ الممرضات السعوديين الممارسين للعمل التمريضي من حوالي خمس سنوات أو أكثر في هذه المهنة.

● الممرضين/ الممرضات السعوديين الذين تركوا مهنة التمريض.

فإذا أنت ممرض/ ممرضة- سعودي و ممارس أو لم تعد تمارس العمل التمريضي، أود أن ادعوك إلى المشاركة في هذا البحث العلمي.

انشاء الله سوف يتم جمع البيانات من الراغبين والراغبات في المشاركة في الفترة من ١٤٢٨/٨/١٥هـ إلى ١٤٢٨/١١/١٥هـ.

علماً إن مساعِدة الباحث سوف تقوم بمقابلة الممرضات الراغبات في المشاركة.

عند الرغبة في المشاركة أو الاستفسار يرجى الاتصال بالباحث إما عن طريق الهاتف الجوال (٠٥٠٦٠٦٨٩٣٨) أو البريد الإلكتروني:

شـاكراً لـكم
الباحث / فـهد بن عبدالله الهذلي
طالب دكتوراه / جامعه موناش ــ استراليا

Appendix C: Explanatory Statement (English Version)

MONASH University

Project title: The lived experiences of Saudi nurses in Saudi Arabia.

My name is Fahad Alhetheli and I am conducting a research study with Dr Joy Lyneham, Senior Lecturer in the School of Nursing and Midwifery, which will count towards my PhD at Monash University.

The aim of this study is to identify the self-perceptions and experiences of Saudi nurses. This study has the potential significance of identifying the status of Saudi nurses in society and providing a direction to improve the professional standing of Saudi nurses.

This study is particularly interested in the views of Saudi nurses with five or more years of nursing experience who are currently working as a nurse or who have left nursing and who are willing to participate in this project.

The study will employ in-depth interview. The interviews will last between 45 mins to one hour and they can be done at a place and time that is suitable for you. The interviews will be tape-recorded and then transcribed. You will have the opportunity to review the draft of the transcript. To maintain confidentiality, participants' names and places of work will be de-identified and replaced with pseudonyms. All aspects of the study will be confidential and access to participants' information is restricted to the researchers. All data collected will be stored for five years, as prescribed by Monash University regulations. I am not anticipating any difficulties or distress during the interview process.

Participation in this research is voluntary and, if you agree to participate, you may withdraw your consent at any time. A report of the study may be submitted for publication. However, no findings that could identify any individual participant will be published. If you have any queries or if you would like to be informed of the research findings, please contact Fahad Alhetheli on +███ ████████ Australia) or ███████████ (Saudi Arabia) or by email at ███████████████████████. The findings will be accessible from 18/10/2010. Thank you for your participation.

Fahad Abdullah Alhetheli

PhD candidate, Monash University, Australia

Should you have any complaint concerning the manner in which this research is conducted, please do not hesitate to contact the Monash University Standing Committee on Ethics in Research Involving Humans at the following address:

The Secretary. The Standing Committee on Ethics in Research Involving Humans.

Building 3d, Research Grants & Ethics Branch

Monash University VIC 3800

Tel: +61 3 9905 2052   Fax: +61 3 9905 1420   Email: scerh@adm.monash.edu.au

Appendix D: Explanatory Statement (Arabic Version)

MONASH University

بيان إيضاحي

عنوان البحث: مفاهيم وتجارب التمريض السعودي.

أقوم بعمل مشروع بحث علمي مع الدكتورة/ جوي لينهام (من مدرسة التمريض، كلية الطب والتمريض والعلوم الصحية في جامعة موناش)، للحصول على درجة الدكتوراة.

والهدف من هذه الدراسه هو التعرف على المفاهيم والخبرات لدى التمريض السعودي حول هذة المهنة. هذه الدراسه قد تكون لها أهمية في تحديد الوضع الحالي للممرضين والممرضات السعوديين ، لغرض تحسين المكانه المهنيه للتمريض السعودي.

هذه الدراسة خاصة بـ :

١- الممرضين/ الممرضات السعوديين الممارسين للعمل التمريضي من حوالي خمس سنوات أو أكثر في هذه المهنة.

٢- الممرضين/ الممرضات السعوديين الذين تركوا مهنة التمريض.

هذه الدراسة تتضمن مقابلة شخصية، المقابلة سوف تكون مسجلة وقد تستغرق من ٤٥الى ٦٠ دقيقة من وقتك ويمكن ان يتم ذلك في الوقت والمكان المناسب لك. وستتاح لك الفرصة لاستعراض تسجيل المقابلة.

نتائج هذا البحث لن تميز أسماء المشاركين أو مكان عملهم لضمان الخصوصية. جدير بالذكر إن المعلومات ستكون خاصة في هذا البحث ومحصورة على الباحثين فقط وسوف تحفظ في مكان أمن لمدة خمس سنوات في الجامعة وذلك حسب أنظمة الجامعة. الأشتراك في هذا البحث طوعاً، ولك حق عدم المشاركة في هذا البحث. نتائج هذا البحث قابله للنشر، في حالة وجود أي إستفسار أومعرفة نتائج البحث الرجاء الاتصال بطالب البحث شخصيا على العنوان المدون ادناه. علما أن النتائج سوف تكون متوفرة إن شاء الله في تاريخ ١٤٣١/١١/١٠

شاكراً لكم المشاركة في هذا البحث

فهد بن عبدالله الهذلي

طالب دكتوراه / جامعه موناش – استراليا

جوال : ٠٠٦١٤٢٣٨٧٦١٩١ (استراليا)

جوال : ٠٥٠٦٠٦٨٩٣٨ (السعودية)

البريد الإلكتروني :

███████████████████

.

Appendix E: Consent Form (English Version)

MONASH University

Consent Form

Title of the research: **The perception and experiences of nursing in Saudi Arabia**

NOTE:

This consent form will remain with the Monash University researcher for their records.

I agree to take part in the Monash University research project specified above. I have had the project explained to me and I have read the Explanatory Statement, which I keep for my records. I understand that agreeing to take part means that I am willing to:

- Be interviewed by the researcher.
- Allow the interview to be audiotaped.

I understand that I will be given a transcript of data concerning me for perusal before it is included in the write up of the research. This consent form is not attached in any way to the interview.

I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way.

I understand that any data that the researcher extracts from the interview for use in reports or published findings will not, under any circumstances, contain names or identifying characteristics.

Participant's name:

Signature:

Date:

Appendix F: Consent Form (Arabic Version)

MONASH University

نموذج موافقة

عنوان البحث: مفاهيم وتجارب التمريض السعودي

ملاحظه : هذا النموذج سيبقى في سجلات الباحث في جامعة موناش باسترالياء.

وقرأت أوافق على المشاركة في هذا البحث المحدد عنوانة اعلاه من جامعة موناش . لقد تم شرح طبيعه هذا البحث

نموذج الإستبيان الذي سوف أحتفظ فية. المشروع واضح لي ، وأنا مستعد على ان:

١ـ اوافق على مقابلة الباحث.

٢ـ اوافق على السماح لمقابلة صوتيه مسجلة.

افهم انة يمكنني الأطلاع على البيانات المسجلة الخاصة بي قبل كتابتها في البحث، وهذا النموذج لن يكون مرفق

عند المقابلة في أي طريقة.

افهم ان مشاركتي طوعيه واستطيع ان اقرر عدم المشاركة في هذا البحث او جزء منة ، واستطيع أن انسحب في

أي مرحلة من مراحل البحث دون معاقبة أو حرمان بأي شكل .

أعلم ان اي بيانات سجلت خلال المقابلة سوف تكون لغرض كتابة البحث أو النشر ولن تحتوي على أي معلومات

شخصية مثل الاسم و تحديد الهوية تحت أي ظرف مهما كلف الأمر .

اسم المشارك :

التوقيع:

التاريخ:

Appendix G: Interview Schedule (English Version)

MONASH University

Interview Schedule

- Tell me about how you decided to become a nurse?

    - What was it about nursing that attracted you in the first place?

- What qualifications do you have?

    - Tell me about your education experience?

- Do you think you were prepared for your first nursing experience as a graduate?

- What do your friends and family think you do as a nurse?

    - How did they react when you told them you were going to be a nurse?

    - Do you tell people that you meet, *you are a nurse*? If not why?

        - How does this make you feel?

- Tell me what are you doing now?

    - (IF not in nursing) what were the circumstances that led you to leave nursing?

- How did you feel about leaving nursing?

    - How did your family and friends react to you leaving nursing?

        - (IF still nursing) What do you like about this area?

    - Do you see yourself staying there for a long period?

- What can be done to support you in nursing?

    - There are a lot of expat nurses in Saudi, do you think they can give good care

        to your patients given they cannot speak Arabic?

- What is your experience of practice?

    - Do you feel confident in all your nursing skills?

    - What are the plans for your future?

The questions asked in a phenomenological interview are shaped by the responses to the

above questions. A frequent follow on question will be, '*how did that make you feel'* or '*what*

was your feeling about 'x''

Appendix I: Approval of the Standing Committee on Ethics in Research Involving Humans

MONASH University

Standing Committee on Ethics in Research Involving Humans (SCERH)
Research Office

Dr Joy Lyneham
School of Nursing and Midwifery
Faculty of Medicine, Nursing and Health Sciences
Peninsula Campus

7 June 2007

CF07/1510 - 2007/0440: The perceptions and experiences of nursing in Saudi Arabia

Dear Researchers,

The Standing Committee on Ethics in Research (SCERH) approved the above project at meeting C3/2007 on 5 June 2007.

Terms of approval

1. This project is approved for five years from the date of this letter and this approval is only valid whilst you hold a position at Monash University.
2. It is the responsibility of the Chief Investigator to ensure that all information that is pending (such as permission letters from organisations) is forwarded to SCERH, if not done already. Research cannot begin at any organisation until SCERH receives a letter of permission from that organisation. You will then receive a letter from SCERH confirming that we have received a letter from each organisation.
3. It is the responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval and to ensure the project is conducted as approved by SCERH.
4. You should notify SCERH immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.
5. The Explanatory Statement must be on Monash University letterhead and the Monash University complaints clause must contain your project number.
6. **Amendments to the approved project:** Changes to any aspect of the project require the submission of a Request for Amendment form to SCERH and must not begin without written approval from SCERH. Substantial variations may require a new application.
7. **Future correspondence:** Please quote the project number and project title above in any further correspondence.
8. **Annual reports:** Continued approval of this project is dependent on the submission of an Annual Report. Please provide the Committee with an Annual Report determined by the date of your letter of approval.
9. **Final report:** A Final Report should be provided at the conclusion of the project. SCERH should be notified if the project is discontinued before the expected date of completion.
10. **Monitoring:** Projects may be subject to an audit or any other form of monitoring by SCERH at any time.
11. **Retention and storage of data:** The Chief Investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.

All forms can be accessed at our website www.monash.edu.au/research/ethics/human/index.html

We wish you well with your research.

Mrs Lyn Johannessen
Acting Human Ethics Officer (on behalf of SCERH)

Cc: Mr Fahad Alhetheli

Postal - Monash University, VIC 3800, Australia
Building 3E, Room 111, Clayton Campus, Wellington Road, Clayton
Telephone +61 3 9905 5490   Facsimile +61 3 9905 1420
Email scerh@adm.monash.edu.au   www.monash.edu.au/research/ethics/human/index.html
CRICOS Provider No. 00008C   ABN 12 377 614 012

Appendix J: Ethical Approval (Ministry Of Health, Saudi Arabia)

بسم الله الرحمن الرحيم

المملكة العربية السعودية
وزارة الصحة

فاكس عاجل

الرقم: ٤٩٨٦١٩٢/
التاريخ: ١٧/١٠ ١٤٢٩هـ
المشفوعات:

سعادة مدير عام الشئون الصحية بمنطقة الرياض   المحترم
سعادة مدير عام الشئون الصحية بمنطقة القصيم   المحترم
سعادة مدير عام الشئون الصحية بالمنطقة الشرقية   المحترم
سعادة مدير عام الشئون الصحية بمنطقة نجران   المحترم
سعادة مدير عام الشئون الصحية بمنطقة حائل   المحترم
سعادة مدير الشئون الصحية بمحافظة جدة   المحترم

السلام عليكم ورحمة الله وبركاته .

أرفق لسعادتكم بطيه صورة من خطاب مدير إدارة التدريب والابتعاث والتعليم الطبي والبحوث بالمديرية العامة للشئون الصحية بالقصيم رقم ٥/٤٤/٧٤٢ في ١٤٢٨/١٠/٢٥هـ المتضمن طلب مبتعث الوزارة فهد عبد الله عايد الهذلي للحصول على درجة الدكتوراة من جامعة موناش باستراليا عمل بحث بعنوان (مفاهيم وتجارب التمريض السعودي) الخاصة بالممرضين والممرضات السعوديين الممارسين للعمل التمريضي في المستشفيات والمراكز الصحية بالوزارة من حوالي خمس سنوات أو أكثر في مهنة التمريض و الممرضين والممرضات السعوديين الذين تركوا مهنة التمريض بالوزارة حيث حازت الدراسة على موافقة أخلاقيات البحوث في مرجعه وتجرى الدراسة تحت إشراف إدارة التدريب والابتعاث والتعليم الطبي والبحوث بالقصيم وستكون هذه الدراسة في مناطق (الرياض- القصيم- الشرقية – نجران- جده- حائل)وطلبهم تسهيل مهمة الباحث حيال ذلك . وحيث أن المذكور لديه موافقة على القيام برحله علميه بناءا على خطاب أمين عام لجنة تدريب وابتعاث موظفي الخدمة المدنية رقم ٣٢٨٧٠ وتاريخ ١٤٢٨/٧/١هـ مرفقاً به القرار رقم ٤٤٤ وتاريخ ١٤٢٨/٦/٢٥هـ والخاص بالموافقة على قيام مبتعث الوزارة / فهد عبدا لله عايد الهذلي برحلة علمية داخل المملكة العربية السعودية لمدة ثلاثة أشهر لجمع المعلومات اللازمة لبحثه للحصول على درجة الدكتوراه .

أمل التكرم بالاطلاع والتوجيه لمن يلزم لديكم بذلك وتسهيل مهمة الباحث لدى وصوله على الا تتحمل الوزارة اى أعباء ماليه جراء ذلك واشعارنا بمايتم .

مع أطيب تحياتي ،،،، ،

مدير عام التدريب والتعليم الطبي والبحوث بالانابه
د /قطنان بن حسين الجحدلي