https://doi.org/10.53964/jmnpr.2024009

https://www.innovationforever.com

Journal of
Modern Nursing Practice and Research

ISSN 2708-2202 (Online)

Open Access

Review

Nurse-patient Relationships and Expatiate Nurse in Saudi Arabia: Challenges and Implications

Ohood Alkaabi[1#*], Carole Orchard[1#]

[1]Arthur Labatt Family School of Nursing, Faculty of Health Sciences, Western University, London, ON, Canada

[#]Both authors contributed equally to this manuscript.

[*]**Correspondence to: Ohood Alkaabi,** Arthur Labatt Family School of Nursing, Faculty of Health Sciences, Western University, London, ON N6A 5B9, Canada; Email: oalkaabi@uwo.ca

Received: April 22, 2024 **Revised:** June 12, 2024 **Accepted:** June 17, 2024 **Published:** June 18, 2024

Abstract

The therapeutic relationships-form of the nurse-patient-relationship are formed within short durations to address patient care needs quickly and effectively, as well as psychosocial support for family or friends. The purpose of this paper is to focus on challenges that nurses can experience when trying to establish therapeutic relationships with their patients when they are in their communications due to cultural, religious or language challenges. Databases such as PubMed, Scopus, and ProQuest, were used to obtain a comprehensive overview of the literature. The synthesis of the articles grouped together to identify common patterns or themes. The data was integrated into the therapeutic relationship and its elements. The disparities between nurses and their patients may hinder nurses' abilities to establish a therapeutic nurse-patient relationship with their Saudi patients and families. This interruption in creating such relationships may lead to a decrease in the quality of care. Effective communication seems to be associated with the intimacy of the relationship, which creates a sense of trust. A nurse's empathy that balances power between both parties provides a perception of respect for the patients. Pre-departure education programs may help expatriate nurses learn about the culture of their hosts prior to their arrival in that country. These programs should provide opportunities for expatriate nurses to learn about, discuss and explore how to 'fit into' these cultural practices. Mentoring programs that electronically connect previous nurses who worked in the host country with new recruits in that country should be provided. Thus, the recruited nurses can benefit from their colleagues' experiences and have a more realistic view of what working in that host country is like. This review will help to raise leaders' awareness about the challenges experienced by expatriate nurses who deliver care to patients with divergent belief systems than their own.

Keywords: therapeutic relationships, challenges, expatriate nurse, effective communication, Saudi Arabia

Citation: Alkaabi O, Orchard C. Nurse-patient Relationships and Expatiate Nurse in Saudi Arabia: Challenges and Implications. *J Mod Nurs Pract Res*, 2024; 4(2): 9. DOI: 10.53964/jmnpr.2024009.

https://doi.org/10.53964/jmnpr.2024009

1 INTRODUCTION

The nurse-patient relationship is viewed as a fundamental and core concept of nursing practice[1,2]. The nurse-patient relationship relates to a mutual, reciprocal partnership between nurses and each person involved (i.e., nurses and patients/families)[3]. There are four types of mutual relationships have been identified, including clinical relationships (brief, superficial, courteous interaction with short-term patients to treat minor concerns), therapeutic relationships (formed within short durations to address patient care needs quickly and effectively as well as psychosocial support for family or friends), connected relationships (occurs when patient choose to trust a nurse, and a nurse is willing to professionally advocate for the patient), and over-involved relationships (occurs when a relationship goes beyond work hours and beyond professional boundaries)[4]. This paper will focus on therapeutic relationships that are between nurses and their patients.

Therapeutic relationships in nursing are described as unique interactions occurring between nurses and patients where both of their unique beliefs and expectations are brought into patterns of relating to each other within nurses' professional boundaries[5]. While it has long been suggested such relationships take periods of time to develop[5], today, in the rapid pace of healthcare, limited time is available for the development of such relationships. Therefore, nurses need to 'fast-track' creating these interactional patterns with patients and families. For example, caring interactions require nurses to demonstrate unique perspectives they have of their patients, creating opportunities to want to get to know them while providing a sense of security and comfort in the patient's care setting. To convey this sense, nurses need to use strategies that create an atmosphere to help patients 'open up' and share their thoughts, feelings, and concerns[6,7]. It is suggested that such sharing has the potential for patients to feel their own worth through re-affirming their intrinsic value[7]. To achieve this relationship goal, nurses need to enact both verbal and non-verbal forms of communication[8]. Thus, therapeutic relationship building between nurses and patients necessitates both an ability to communicate in a common language as well as the use of body language that provides authenticity to the language used by the nurse. This integration of both forms of communication is particularly important within the parties' religious and cultural beliefs. Therefore, when such beliefs are not consistent between the nurse and the patient, their capacity to build therapeutic relationships can be challenged.

In the multicultural world of today many nurses are faced with the need to develop therapeutic relationships with patients who have divergent belief systems than their own. Furthermore, when one of the parties cannot speak or understand the predominant language in that setting, there may be difficulties in creating such therapeutic relationships. Therefore, the purpose of this paper is to focus on challenges that nurses can experience when trying to establish therapeutic relationships with their patients when there are impediments in their communications due to cultural, religious or language challenges. This paper will use the Kingdom of Saudi Arabia as an example of where expatriate nurses often experience such challenges. The choice of Saudi Arabia is due to the country's long-standing experience in providing nursing care to patients by expatriate nurses from a wide variety of countries.

2 BACKGROUND

Historically, the nursing profession in Saudi Arabia has been affected by socio-cultural factors such as being viewed as a low-privilege profession, leading to a poor image of nurses in Saudi communities[9,10]. As an outcome, there have been low enrolment rates of Saudi nationals in nursing schools[10]. This ultimately contributes to the lack of a Saudi nursing workforce[10]. This lack of Saudi national nurses in the country's hospitals has resulted in a reliance on expatriate nurses. These expatriate nurses come from more than 40 countries, primarily India and the Philippines, with the remaining from North America, the United Kingdom, Australia, South Africa, Malaysia, and other Middle Eastern countries[11]. This expatriate nursing workforce comprised 60% of the country's nurses[11]. Only 36.5% of the total nurse workforce are nationals, with a significant proportion of these nurses working in administrative positions[12]. Hence, this ongoing dependency on an expatriate nursing workforce can create differing cultural, religious or interactive expectations between Saudi patients and their expatriate nurses than desired. This results in expatriate nurses often experiencing a number of challenges as they assume their nursing roles. These challenges are often associated with religious beliefs, cultural and societal practices, and language barriers that are vastly different from their own. The expatriate nurses have their own beliefs and values that may differ from those in the Saudi culture. They may not have sufficient knowledge about the local culture, so their practice might omit the importance of Islamic beliefs and values for their clients[13], which is considered an obstacle to achieving culturally sensitive client care. Even nurses coming from what appear to be similar cultural backgrounds may be challenged by these disparities. These disparities may hinder nurses' abilities to establish therapeutic nurse-patient relationships with their Saudi patients and families. This interruption in creating such relationships may lead to a decrease in the quality of care and may impact patient and nurse safety.

3 LITERATURE REVIEW SEARCH

The PubMed, Scopus, ProQuest, and Google Scholar databases and the Saudi Digital Library were used to conduct a review of the literature. To obtain a comprehensive overview of existing literature, manual searches of

references from published literature and scholarly full-text articles and dissertations were carried out to obtain relevant articles about the issue addressed in this article. Both quantitative and qualitative research written in English and published mainly within the last two decades (2000-2023) were reviewed. The keywords were "Therapeutic Relationship", Nurses-Patient Relationship", Nurses-Patient Relationship Elements", "Intimacy", "Empathy", "Respect", "Power", "Trust", and "Saudi Arabia". Those key words were combined with Expatriate nurses".

4 DATA ANALYSIS

The goal of this review was to identify the challenges that expatriate nurses may encounter in establishing therapeutic relationships with their patients due to cultural, religious, or language communication barriers. The synthesis of the articles grouped together to identify common patterns or themes. The data was classified based on the component of the nurse-patient relationship. The data falling into these elements were coded. The codes were constantly revised and compared. The data was integrated into the therapeutic relationship and its elements.

5 THE FINDINGS FROM THE REVIEW

5.1 Therapeutic Nurse-Patient Relationship

Therapeutic nurse-patient relationships involve a person-to-person intimacy between patients and nurses that facilitates shared and intersubjective understanding[14] and shared power through balanced expectations[15] within agreed-upon boundaries[16]. Thus, for a therapeutic relationship to occur, there needs to be genuine empathy that allows for approachability, availability for a beneficial presence and engagement among the parties that reflects respect and trust to allow for the achievement of progress toward care outcomes[17]. Scholars have studied the nature of the nurse-patient relationship among psychiatric nurses[14,17], home health care[18], accident and emergency departments[19] and general nursing practice[16]. From these studies, it can be concluded that therapeutic relationships support both patient's psychological and physical needs.

To achieve a therapeutic nurse-patient relationship, effective communication using shared meanings of both verbalized words and body language, or other forms of non-verbal actions is essential. Studies have reported variations in what constitutes the effectiveness of such relationships. The effectiveness of relationships requires nurses to communicate in a language that is easily understood but may also vary between nurses and their patients, with the former being dissatisfied and the latter satisfied[20]. Patients in tertiary hospitals in Northwest Nigeria felt an effective relationship with their local nurses[20], while variations in dialects can undermine the effectiveness of nurse-patient relationships in Iran even when Iranian nurses speak the same language as their patients[21]. Another Iranian study found that nurses' patterns of communication can also impede relationships[22]. Finally, in a study in Australia, authors found that when nurses and patients experience divergent cultural and linguistic backgrounds within their own country, therapeutic relationships can also be undermined[23,24]. In countries such as Saudi Arabia and the United Arab Emirates, where large numbers of expatriate nurses are providing care, multicultural divergence between nurses and their patients is likely to exist. Therefore, creating an effective therapeutic relationship necessitates nurses to focus on their verbal and non-verbal communication when interacting with their patients. Effective communication seems to be associated with the intimacy of the relationship, which creates a sense of trust. To achieve this, a nurse's empathy that balances power between both parties provides a perception of respect for the patient. Each of these elements will be discussed below.

5.2 Intimacy

Intimacy is a feeling of being emotionally connected and supported that allows for the sharing of feelings and experiences. Intimacy requires reciprocity, self-disclosure, and self-awareness by reflecting on your own personal interactions with patients[25]. Intimacy is achieved through mutual understanding among two parties[25]. Intimacy then relates to the quality of an established relationship that must demonstrate reciprocal trust and emotional closeness with each other when both parties are believed to be able to share their thoughts and feelings with each other. However, the degree of closeness required needs to be within the boundaries of professional nursing practice.

Nurses are encouraged to establish caring with empathy and kindness while maintaining a degree of professional emotional detachment[26], allowing for boundaries to be established with their patients. Setting boundaries within these intimate nurse-patient relationships is believed to help maintain a patient's dignity, autonomy and privacy while maintaining a nurse's professional standards of practice[27]. For example, in the Canadian province of Ontario, nurses are required to maintain their professional intimacy within the province's guidelines for the Freedom of Information and Protection of Privacy Act[28]. Nurses' professional intimacy then involves access, with permission, to patients' personal information to enact their nursing skills through activities such as treatments (e.g., dressings, bathing, and feeding). Intimacy can also provide insight into a patient's psychosocial, mental, and spiritual well-being. Intimacy within nurse-patient relationships has been reported to prevent patients from suffering in silence by helping them to share deep and troubling feelings[29] and can provide an intimate and trustworthy relationship during traumatic life experiences[30]. Thus, professional intimacy allows for a connection to be created with their patients.

At the same time, nurses can benefit from this sense of professional intimacy by gaining "reward and satisfaction"

from their relationships with their patients and facilitating an empathetic understanding between both parties[31-33].

5.3 Empathy

Empathy has been defined as comprising both affective and cognitive components. Affective empathy is associated with an emotional understanding of another's feelings, while cognitive empathy is related to an intellectual understanding of what another is experiencing[34]. In nursing, empathy is known as a clinical skill that can be taught, acquired, refined, improved, and measured[35,36]. Empathy allows nurses to develop a perception of their client's world[37]. Empathy, then, is a recognition of a lived experience of others without actually experiencing them through a deep understanding of another person's feelings[34,37].

Empathy is a foundation of nursing care and an indicator of effective nursing care[37,38]. Nurse empathy has been linked to increased patient satisfaction[39], self-concept and self-disclosure[40]. Patient-perceived empathy decreased patient distress[37]. Nurses' empathy is positively associated with patients' feelings of closeness through compassion, recognition and respect shared by their nurses[41].

5.4 Respect

Respect is a basic human need, and an essential patient right in their health care provision[41]. It is also a cornerstone of nursing practice[42,43]. While respect is an abstract concept, it is conveyed by nurses through their careful listening to and appreciating what patients verbally and non-verbally share. It is enacted by how nurses demonstrate their courtesy and caring for patients as unique persons[44,45], and by maintaining patients' dignity and worth[41]. Respect is demonstrated when nurses value and accept patients as their own unique individuals, even during difficult situations[46]. Behaviours that demonstrate respect are reported to contribute to nurturing nurse's relationships with their patients. It was reported that nurses' behaviours demonstrating respect could include supporting patients' choices and wishes by "*giving [them] space in the encounter,*" "*allowing them to be angry,*" and "*waiting until they were ready to disclose their personal needs and feelings*" (p. 481)[47].

Although there are limited empirical studies addressing the concept of respect in nursing literature, respectful behaviours seem to relate to positive patient outcomes. The researchers found that respect conveyed by nurses has a positive association with patients' satisfaction with their nursing care[44,48]. This satisfaction also seems to be associated with patients seeking and following health professionals' advice for both preventative and needed care[49,50]. Respect has been reported to have a positive impact on self-esteem, illness perception, and trust in nurse-patient relationships[51]. The patients' advocacy was found to have an association with valuing dignity and respecting patients' uniqueness[52]. When nurses consider patients' opinions and preferences in decision-related care delivery, patients are more likely to have a sense of power over their health status. Thus, maintaining respect for patients within nurse-patient relationships contributes to a relatively equal power-sharing between both parties.

5.5 Power

Power appears to be inherent within the nursing profession. This evolves from the status provided to a nurse as a professional within the healthcare system. This power over patients may hinder the achievement of desired patient outcomes from nurse-patient relationships. The conceptualization of power varies. Theorists have viewed the term power from two perspectives: "power to" and "power over." Through the lens of "power to," power is defined as the capability of generating a specific effect and possession of control, influence or authority[53]. While in a therapeutic relationship, it is theorized that both nurses and patients share equally in their roles, patients' vulnerability and dependency on nurses during illness experiences can alter attempts to maintain equality between both[29].

On the other hand, "power over" was defined as the ability and potential to influence others and may be exercised through a variety of resources, such as offering rewards, controlling information, using ingratiation or appeasement[53]. Nurses' specialized knowledge and their position allow them to have access to privileged information, authority and influence in the healthcare system[54]. Hence, nurses have greater power within health care systems than do their patients.

The nursing literature has identified many subtle manifestations of exercising power within the nurse-patient relationship. Nurses used authoritative language to direct patients' actions[55,56]. Examples of subtle manifestations of power include using scientific vocabulary by dictating topics for discussion, disregarding patients' initiatives through interrupting and questioning, controlling time available to interact with patients, and/or use of persuasive language[55,56]. Exercising power over patients leads patients to feel objectified and disempowered[53]. When both patients and nurses collaborate with each other, power can be shared[57]. An equalization of power can be achieved through shared decision-making, openness, and reciprocity between nurses and their patients, mutually determining care goals), which in turn supports a respectful and trusting relationship[53,58]. Therefore, effective nurse-patient therapeutic relationships necessitate the establishment of an environment that comprises an intimate, empathetic appreciation of each other with mutual respect that allows for power sharing between the parties, leading to trusting relationships.

5.6 Trust

Trust is an integral component of nurse-patient relationships[59]. The concept of trust in nurse-patient relationships has been broadly discussed in nursing literature. Trust in the nurse-patient relationship is described as an attitude bound to time and space in which one relies with confidence on someone or something[60]. Trust can also be viewed as a willingness to engage oneself, even when feeling vulnerable in a relationship[60,61]. Trust has been conceptualized as a core and normative ethical concept of nursing practice[61]. Nurses need to demonstrate their ability to establish trust within their patients through ensuring open and honest information sharing that can lead to appropriate care provision[62]. Thus, a trusting nurse-patient relationship enhances patients' confidence in their nurses and allows them to feel open and comfortable sharing words, feelings, and concerns. When present, nurses are able to participate therapeutically with their patients to reach expected health goals[63].

Trust in nurse-patient relationships has been associated with quality patient care and positive outcomes[64]. Patient satisfaction with nurse practitioner care was found to have a positive association with trust[65]. In addition, patients' chronic illness experiences were identified as both meaningful and powerful when trust in the nurse-patient relationship was present[66]. Trust was also found to raise hope in patients suffering from borderline personality disorders[67], depression and drug problems[68]. Trusted nurse-patient relationships enable open discussion of shared issues and can further psychological preparation and reassurance for patients during treatments (for example, tracheostomy tube changes)[69] and incentives to continue living[47]. The nurse-patient relationships were perceived as trustworthy when four themes were present, including understanding the patient's needs, exhibiting caring behaviours and attitudes, providing holistic care, and advocating for patient desires and choices[47]. Trusting nurse-patient relationships, therefore, contributes to reaching optimum patient outcomes.

In summary, intimacy, empathy, respect, power, and trust are key elements that influence the establishment of effective nurse-patient relationships that contribute to achieving desirable patient outcomes. The development of these relationships requires nurses to interact and communicate in a clear and distinct way with their patients[70]. However, within a divergent nursing workplace where culture, religion, and language are not consistent between the parties, building nurse-patient relationships can be challenging. Thus, challenges affecting such relationship development will be discussed, using the expatriate nursing workforce in Saudi Arabia as an exemplar in exploring its impact on the ability for effectiveness in nurse-patient relationships to achieve the above will be presented next.

6 DISCUSSION

6.1 Cultural Challenges

Many expatriate nurses come from a culture that is incongruent with the cultural roots in Saudi Arabia. They may also be inadequately equipped to adapt to these variants prior to arriving for their contracted work. It appears that few recruiters of these nurses provide sufficient orientation to the cultural differences prior to their arrival in the country. This lack of orientation has been reported in the nursing literature within the context of Saudi Arabia, where expatriate nurses have limited knowledge about Saudi Arabian patient practices[71,72]. This has been reported to lead to perceptions of unsafe practices. Non-Arabic nurses perceived clinical practice as unsafe and struggled to meet their perceived Saudi Arabian patients' cultural and religious/spiritual needs while maintaining a high standard of nursing care[73]. While expatriate nurses from other Middle Eastern countries seem to share similar religious practices, cultural practices within these nurses' backgrounds vary with those of Saudi Arabia. The Saudi culture is characterized by a blend of Arabic tribal traditions and customs and an Islamic worldview, which shapes the mindset and behaviour of the Saudi people[73]. Saudi patients, especially women, present a shyness and adhere to honour and, when not adhered to, experience shame. To maintain honour, females are expected to exercise modesty and decency by maintaining appropriate garments that are loose and cover the body, including arms and legs. Women are expected to speak quietly and calmly and avoid discussing embarrassing topics[74]. Within Saudi Arabia, adherence to honour is expected within the family; violations by one member can bring shame to all family members[75]. Challenges to a family's honour can include uncivil behaviour, sexual and unethical misconduct, ignorance and poor treatment of elderly or vulnerable people[76]. Hence, family involvement in its member's lives is a very significant contributor to each member's emotional, social and psychological well-being[77]. The family and in particular the oldest male member, is considered as the primary decision-maker, not the individual person (patient)[77]. Therefore, a female patient is expected to turn to this family decision-maker in all decisions regarding her care. The lack of knowledge about Saudi values, cultural norms and expected social behaviour can contribute to and lead to nurses' misunderstanding when female or younger patients defer a decision to the eldest male family member regarding their care. Trying to force such patients to make decisions can potentially embarrass or even tarnish a person's honour. For example, in Saudi Arabia, nurses must discuss a patient's condition with the family first, not the individual, which can challenge nurses' ethical obligations under their home country's regulated professional codes of conduct[78]. Such family decision-making in an individual's care has been found to create stressful situations for many expatriate nurses[77].

Furthermore, traditional medicine is often used together

with contemporary medicine by Saudi patients. The lack of cultural understanding may impact Saudi patients who choose to apply traditional medicine to their care[78]. For example, the first author's mother believes that the Myrrh Plant is more efficient and effective in curing an abscess infection than an antibiotic. Honey and black cumin (Nigella seeds) are also other traditional medications used by Saudi patients. Therefore, creating effective nurse-patient relationships among expatriate nurses in Saudi Arabia necessitates the development of their cultural competence to understand these cultural beliefs and practices related to their Saudi patients' health and illness[79].

Cultural competence is a philosophy of providing the best quality of care regardless of cultural, religious, and language differences between nurses and those to whom they care[80]. Cultural competence is enacted through gaining unique cultural knowledge to patients gained from learning others' world views, languages, and differing cultural beliefs and practices[81]. In Saudi Arabia, expatriate nurses reported their cultural incompetence with their Saudi patients[82]. Although some studies found that Saudi patients trusted and preferred expatriate nurses due to their perceived technical competence, they also reported these same nurses' level of cultural incompetence[82]. The key finding focused on their interpersonal therapeutic communication caused by perceived ignorance of the local language, culture and religion[83]. Thus, these nurses' technical competence was valued, while their communication and practices were viewed as unsatisfactory by these same Saudi persons.

It is documented that Saudi patients showed less respect to some nurses' which seemed to be explained by patients' perceived cultural barriers between both parties[84,85]. In response, Saudi patients may use forms of noncompliance when receiving care that is not culturally sensitive to them. Expatriate nurses experiencing such patient reactions have reported feelings of vulnerability and intimidation[71,80]. When not dealt with, these shared feelings may lead to disrespect between both patients and their expatriate nurses.

Cultural competence within interpersonal relationships requires the creation of trust between patients and their nurses[81]. Interpersonal skills were significant facilitators in building trust. Among Saudi adult oncology inpatients trust seems to be related to how Saudi patients felt expatriate nurses considered their cultural preferences in their nursing care[86]. Thus, when patients' beliefs and traditions are integrated into their nursing care, trust in their nurse-patient relationship is further enhanced[87]. However, this sense of trust can also be lost when there are violations of these cultural traditions and may even occur from delays in nurses responding to their Saudi patients. When trust is lost, nurses may be labelled as ignorant or negligent. In addition to cultural challenges for expatriated nurses, the unique approach to religious practices may further affect their evolving nurse-patient therapeutic relationships.

6.2 Religion Challenges

A strict practice of religion often presents cross-cultural conflicts between patients and their families with non-Muslim expatriate health care practitioners[88]. Islam is a powerful influencing factor contributing to the Saudi cultural practices and beliefs[78]. Nursing practice in Saudi Arabia is therefore influenced by actions and attitudes guided by Islam[78]. Expatriate nurses practicing in Saudi Arabia without an understanding of this influence can be faced with further challenges.

Several Islamic practices have an impact on nursing care, including relational restrictions, long visiting times, modesty and face covering, and spiritual practice.

6.2.1 Relational Restrictions

In Islam relational restrictions are specified within and between opposite genders. The intimacy then between nurses and patients is impacted when the patient is the opposite gender to the nurse and may be limited in some situations. Islam prohibits touching, even shaking hands, between those who are neither related nor are of the opposite gender. For example, it is uncommon for a male professional to interview a Saudi female patient without the presence of a mentally competent-related male[78]. Female Saudi patients are also expected to be cared for by a female nurse.

Decision-making related to treatments or sharing of news cannot be done directly with a female patient. All health care decisions, therefore, need to be made with the eldest male member of the family in the presence of the patient. A female patient also cannot be discharged from a health setting without an accompanying male member of the person's family. When such practices cannot be enacted due to staffing issues, negotiation with the eldest family member is required. Thus, the importance of respecting relational restrictions is a key aspect for expatriate nurses to demonstrate respect when interacting and creating nurse-patient relationships.

6.2.2 Modesty and Face Covering

A religious norm in Saudi Arabia requires all females to wear a Hijab, which is inclusive of covering their face, head, and body when non-related men are present[78]. Face covering represents modesty[78]. At the same time face covering can both block non-verbal communication and may interfere with a nurse's patient assessment. For example, observation of facial expression to assess for pain severity, or physical reactions in a physician's presence. As a result, nurses may be unable to adequately identify and respond to patients when they are in pain. If expatriate nurses are not aware of these restrictions, patients' sense of modesty may be violated.

6.2.3 Long Visiting Time

Islamic teachings encourage the visiting of sick patients by relatives, friends, and neighbours. These visitors may travel from long distances and stay throughout the visiting time and beyond that if it is possible. This practice results in accumulating a large number of visitors for in-patients, which can interfere with healthcare delivery. Admitted patients will be embarrassed if a nurse asks visitors to leave either for care delivery or an end to visiting time[78]. Saudi citizens often ignore visiting hours and, when forced to leave, may view such direction as disrespectful. Therefore, a lack of knowledge and understanding of these practices may be interpreted as an absence of empathy within nurse-patient relationships.

6.2.4 Spiritual Healing Practices

Spiritual healing practices are widely used among Saudi patients. As part of the nurse-patient relationship, nurses need to both explore and respect all practices being used while building relationships with both patients and their families[78].

Common spiritual healing practices among Saudis are those advised according to teachings in the Noble Qur'an and (or) Sunnah. Spiritual treatments among Saudi persons include recitation of verses of the Noble Qur'an and specific sayings of the Prophet Mohammad, Zamzam water (obtained from Zamzam well in the Holy Mosque in Makkah), At the time of birth "Ko'hl" -a charcoal substance is applied over the newborn's eyes is believed to prevent effects of the "evil eye"[72]. Thus, expatriate nurses who neither show awareness of nor sensitivity to such practices will be perceived as not being empathic, which may impact the relationships they have with their Saudi patients.

6.3 Language Challenges

In Saudi Arabia, Arabic is the official spoken language with variations in regional dialects[78]. Although the English language is taught in schools, the majority of Saudi patients neither speak nor understand English[82]. Arabic dialects also change pronunciation and can change word meanings[82]. Communicating through both verbal or non-verbal forms, are fundamental skills for gaining and sharing information in any culture[89]. However, expatriate nurses are not required by contracts to acquire a level of Arabic to be able to practice in Saudi Arabia. Indeed, only a few expatriate nurses have mastered the Arabic language.

Communication is a two-way process involving sending and receiving messages via a variety of means. Positive and effective communication is achieved through proper understanding and interpretation of shared language and the meaning of symbols used by both parties[90]. A shared language is, therefore, an essential tool to effectively establish relationships between nurses and their patients[91]. Effective communication among expatriate nurses and Saudi patients can be challenging due to their lack of the Arabic language. A lack of shared meaning and symbols communicated can potentially block the building of relationships between the two parties[92]. There have been three obstacles identified hampering effective communication between expatriate nurses and their Saudi patients, including language differences with patients who cannot speak English, cultural taboos in expressing pain, and concerns relating to gender segregation[82]. This latter obstacle can increase female expatriate nurses' discomfort and hinder communication when caring for male patients.

Language differences and symbols used in exchanges may lead to a loss of mutual respect between expatriate nurses and patients[84]. In addition, these communicative gaps may cause nurses to avoid initiating a conversation with their patients or their families, leading to perceived nurses' disrespect for patients[84]. Although non-verbal communication is commonly used between Saudi patients and expat nurses to overcome these gaps, such communication is frequently misinterpreted by patients[77,93]. For example, the clicking of fingers to attract a patient's attention may be perceived as offensive and misinterpreted by patients[77]. The use of direct eye contact with patients can also be misunderstood as disrespectful behaviour[93].

Limited Arabic fluency prevents nurses from establishing intimacy with their Saudi patients. When intimacy is not present, self-disclosure related to their needs for care may be withheld – a key principle within nurse-patient relationships. If Arabic was a norm among expatriate nurses, it is likely that such nurse-patient relationships could evolve as patients prefer to openly use their native language to discuss their health problems, their homes, and family. In doing so, they may also wish to ask expatriate nurses about their background and about their home country. Expatriate nurses who have some Arabic language capabilities are often limited to simple discussions as their competency in the language does not allow for understanding long sentences and some dialects[77].

An alternate use of verbal means is non-verbal communication for those without Arabic fluency. However, cultural limitations around certain aspects of non-verbal communication with the opposite gender (for example, touch, spatial limits, and eye contact) can limit the development of intimacy and empathy within nurse-patient relationships[94]. In a study of South African nurses working in Saudi Arabia reported their difficulty in non-verbal communication with Saudi women patients because of head, face, and body cover[94]. Other factors include patients limiting responses to only listening and smiling, preventing nurses from being able to interpret patient behaviours through only clinical monitoring and working with their patients in a detached manner[77]. Without common language sharing, difficulty in creating trust between nurses and Saudi patients is likely to impede the creation of therapeutic nurse-patient relationships[92].

When such relationships are not able to evolve, it may lead to nurses inadvertently exerting more expert power over Saudi patients. Saudi patients may perceive messages as commands or orders, which make Saudi patients feel uncomfortable, powerless and passive; thus, they distance themselves from their expatriate nurses.

The inability to speak the same language as their patients creates stress and fear of the unknown, increasing anxiety in patients during care provision. This anxiety increases when language includes medical terms when explaining any procedures being planned for or undertaken[92]. Therefore, when an expatriate nurse not fluent in the Arabic language uses medical terminology or jargon, Saudi patients may be frustrated and feel uncertain and insecure in the care they receive. Consequently, language barriers can create mistrust within patients in the care they receive. Thus, this mistrust then extends into their nurse-patient relationships, causing tensions and aggressive behaviour between nurses and patients.

In summary, a lack of cultural knowledge and competence has the capacity to impact on establishing respect, power and trust within nurse-patient relationships when expatriate nurses with divergent cultural beliefs from their Saudi patients try to interact with each other. Nursing practice in Saudi Arabia is strongly influenced by Islam religion through the enforcement of modesty, face cover, touching restrictions and encouragement of spiritual healing. Nurses' failure to maintain these practices may hinder establishing effective nurse-patient relationships. The inability of expatriate nurses to establish effective nurse-patient relationships can lead to perceptions of a lack of respect, intimacy, and empathy toward their Saudi patients. Ineffective nurse-patient relationships can result in exerting unequal power between the parties due to both the nurses' varying levels of cultural competence and ability to communicate in the Arabic language with their patients. Therefore, it is important to address the implications and solutions of the use of expatriate nurses in relation to nursing management, practice and research.

7 IMPLICATIONS

7.1 Implications for Nursing Management

International recruitment has been used over the last few decades as a strategy for overcoming nursing shortages in Saudi Arabia. However, cultural differences may adversely affect relationships between expatriate nurses from different beliefs and languages and their patients. Pre-departure education has been recommended by scholars interested in nurse-patient relationships within diverse cultures[95,96]. Therefore, all expatriate nurses coming to Saudi Arabia or other countries are required to receive an intensive pre-departure education about the culture of their hosts prior to their arrival in that country. To achieve this goal nurse administrators and policy makers from hosting countries need to work collaboratively with recruitment agencies for the design of these training programs. These training programs should not only focus on host country cultural norms but also provide opportunities for expatriate nurses to learn about, discuss and explore how to 'fit into' these cultural practices to support respect for their patients.

Once nurses arrive in the host country, they should be provided with mentoring programs that electronically connect previous nurses who worked in the host country with new recruits to that country. This mentoring can include sharing strategies the nurses can use to enhance their communication and practices with their patients that respect the local culture and practices. Such a program could help the new nurses in avoiding people in the host country explaining the practices after a nurse has not addressed them appropriately. The recruited nurses then can benefit from their colleague's experiences and have a more realistic view of what working in that host country is like. After the training programme is developed, it can be evaluated to determine its value in preparing nurses readiness to adapt to their nursing role within the host country.

7.2 Implications for Nursing Practice

While expatriate nurses learn some language of the host country words, it is rarely effective enough to professionally interact with their patients to understand the implicit meanings of subtle linguistic symbols[97]. Therefore, providing well-designed technology, such as a phone interpretation with every expatriate nurse, is extremely important. An electronic interpretation feature on smartphones should be available in the host country's language to fit with the cultural and religious practices and terms used. The use of an electronic interpreter can help to maintain patient privacy and safety to encourage more open discussion about their health issues. Having such interpretation available will likely reduce the stress that expatriate nurses feel while trying to understand and interpret what their host country patients are seeking.

Nursing managers should facilitate cultural knowledge acquisition for expatriate nurses by dedicating time to allowing these nurses to use accessible recourses to self-learn. Expatriate nurses can also be asked to provide case study presentations on how they addressed cultural challenges to respect the cultural and religious norms of patients in their host country.

These peer presentations can provide learning for other nurses. Assessment of expatriate nurses' cultural competence should be a requirement during their probationary period in their contracts and when a cultural conflict is reported to administrators. The lack of fundamental knowledge of the spiritual beliefs of Islamic people contributed to a cultural-blind approach to patient care provision[98]. Western cultural competence tools can be borrowed and modified to fit the host country's values and

beliefs. Importantly, the use of specific cultural competence tools for the host country's context provides opportunities for practice improvement and research.

7.3 Implication for Research

Further research addressing the expatriate nursing workforce and their nurse-patient relationships needs to be conducted. This is particularly relevant in such countries as Saudi Arabia because of the higher percentage of expatriate nurses working with culturally diverse patients. Quantitative studies can assess the impact of expatriate nurses on all components of developing therapeutic nurse-patient relationships, including intimacy, empathy, respect, power and trust. Studies to revaluate existing culture competence to examine the current culture competence model with a heterogeneous sample of expatriate nurses. Then to test the reliability and validity of the tool to reflect current practices. Further studies of expatriate nurses' lived experiences in challenging cultures such as the Islamic culture are needed to be explored, especially the experiences of non-Muslim nurses. This study should also explore patients' perceptions of establishing their relationship with these same expatriate nurses.

8 CONCLUSION

The nurse-patient relationship is a core concept of nursing practice. In every context of nursing practice, nurses need to be equipped to effectively establish therapeutic relationships characterized by intimacy, empathy, respect, equal power, and trust. However, in host countries such as Saudi Arabia, where the nursing workforce heavily depends on expatriate nurses, relationships between these nurses and their host country patients can be impaired. Impairments are due to cultural influences such as Islamic worldview practice and language differences; expatriate nurses have been challenged. Therefore, more effort is needed to facilitate the development and maintenance of relationships between expatriate nurses and their host country patients.

Acknowledgements

There are no other contributors.

Conflicts of Interest

No conflict of interest has been declared by the authors.

Author Contribution

Alkaabi O wrote the main content of this article. Orchard C reviewed and edited the manuscript.

References

[1] Lalwani M, Jan R, Rattani S. Intersecting Pathways: Examining Hildegard Peplau's and Rosemarie Parse's Nursing Theories through a Comparative Lens. *Clin J Nurs Care Pract*, 2023; 7: 009-014.[DOI]

[2] College of Nurses of Ontario. Therapeutic nurse-client relationship. Accessed 2023. Available at:[Web]

[3] Vujanić J, Mikšić Š, Barać I et al. Patients' and Nurses' Perceptions of Importance of Caring Nurse–Patient Interactions: Do They Differ? *Healthcare*, 2022; 10: 554.[DOI]

[4] Morse JM. Negotiating commitment and involvement in the nurse patient relationship. *J Adv Nurs*, 1991; 16: 455-468.[DOI]

[5] Peplau HE. Interpersonal relations in nursing: A conceptual frame of reference for psychodynamic nursing. Red Globe Press London: London, UK, 1988.[DOI]

[6] Groves PS, Bunch JL, Kuehnle F. Increasing a patient's sense of security in the hospital: A theory of trust and nursing action. *Nurs Inq*, 2023; 30: e12569.[DOI]

[7] Rask M, Brunt D. Verbal and social interactions in the nurse patient relationship in forensic psychiatric nursing care: a model and its philosophical and theoretical foundation. *Nurs Inq*, 2007; 14: 169176.176.[DOI]

[8] Sharma NP, Gupta V. Therapeutic communication. StatPearls Publishing: Treasure Island, USA, 2021.

[9] Alboliteeh M. Choosing to become a nurse in Saudi Arabia and the lived experience of new graduates: a mixed methods study [doctor's thesis]. Adelaide, Australia: University of Adelaide; 2015.

[10] Al-Dossary RN. The Saudi Arabian 2030 vision and the nursing profession:The way forward. *Int Nurs Rev*, 2018; 65: 484-490.[DOI]

[11] Al-Dossary RN, Kitsantas P, Maddox PJ. Residency programs and clinical leadership skills among new Saudi graduate nurses. *J Prof Nurs*, 2016; 32: 152-158.[DOI]

[12] Ministry of Health. Health Statistical Year Book 2016, Ministry of Health, Riyadh, Saudi Arabia.

[13] Alkaabi O Babenko-Mould Y, Kerr M, Cranley L, Aboshaiqah A. The impact of Authentic Leadership, Structural Empowerment, Psychological Empowerment, Interpersonal Conflict, and Job Satisfaction on Turnover Intention among Early Career Nurses in Saudi Arabia [doctor's thesis]. Toronto, Canada: University of Toronto; 2023.

[14] Thibeault C. An interpretation of nurse–patient relationships in inpatient psychiatry: Understanding the mindful approach. *Glob Qualit Nurs Res*, 2016; 3: 2333393616630465.[DOI]

[15] McCabe C. Nurse-patient communication: An exploration of patients' experiences. *J Clin Nurs*, 2004; 13: 41-49.[DOI]

[16] O'Connell E. Therapeutic relationships in critical care nursing: A reflection on practice. *Nursing in Critical Care*, 2008; 13: 138-143.[DOI]

[17] Hawamdeh S, Fakhry R. Therapeutic relationships from the psychiatric nurses' perspectives: An interpretative phenomenological study. *Perspect Psychiatr C*, 2014; 50: 178-185.[DOI]

[18] Krityakierne T, Limphattharachai O, Laesanklang W. Nurse patient relationship for multi-period home health care routing and scheduling problem. *Plos one*, 2022; 17: e0268517.[DOI]

[19] Walsh A, Bodaghkhani E, Etchegary H et al. Patient-centered care in the emergency department: a systematic review and meta-ethnographic synthesis. *Int J Emerg Med*,

2022; 15: 36.[DOI]
[20] Igbinlade AS, Anyebe EE, Olorukooba H et al. Level of Nurse-Patient Therapeutic Communication: Perspectives of Nurses and Patients in a Tertiary Hospital in North West Nigeria. *J Nurs Midwifery*, 2020; 1: 1-7.
[21] Anoosheh M, Zarkhah S, Faghihzadeh S et al. Nurse–patient communication barriers in Iranian nursing. *Int Nurs Rev*, 2009; 56: 243249.[DOI]
[22] Afriyie D. Effective communication between nurses and patients: an evolutionary concept analysis. *Brit J Commun Nurs*, 2020; 25: 438-445.[DOI]
[23] Crawford T, Roger P, Candlin S. Tracing the discursive development of rapport in intercultural nurse–patient interactions. *Int J Appl Linguist*, 2017; 27: 636-650.[DOI]
[24] Kaihlanen AM, Hietapakka L, Heponiemi T. Increasing cultural awareness: qualitative study of nurses' perceptions about cultural competence training. *BMC Nurs*, 2019; 18: 1-9.[DOI]
[25] Prager KJ, Shirvani FK, Garcia JJ et al. Intimacy and positive psychology. In: Positive Psychology of Love. Oxford University Press: Oxford, UK, 2013.[DOI]
[26] Dowling M. A concept analysis of intimacy in nursing. *All Ireland J Nurs Midwifery*, 2003; 2: 40-46.
[27] National Council of State Boards of Nursing. Professional boundaries: A nurse's guide to the importance of appropriate professional boundaries. Accessed 2018. Available at:[Web]
[28] College of Nurses of Ontario. *Therapeutic Nurse-Client Relationship*, Revised 2006. College of Nurses of Ontario. Accessed 2017. Available at:[Web]
[29] Dowling M. The sociology of intimacy in the nurse-patient relationship. *Nurs Stand*, 2006; 20.[DOI]
[30] Jiang J, Han P, Liu Y et al. Promotion factors of emergency nurses' post-traumatic growth during the COVID-19 pandemic in Shanghai: A qualitative study. *BMC Nurs*, 2023; 22: 298.[DOI]
[31] Henderson A. Emotional labor and nursing: An under-appreciated aspect of caring work. *Nurs Inq*, 2001; 8: 130138.[DOI]
[32] Williams A. A literature review on the concept of intimacy in nursing. *J Adv Nurs*, 2001; 33: 660-667.[DOI]
[33] Williams A. A study of practising nurses' perceptions and experiences of intimacy within the nurse–patient relationship. *J Adv Nurs*, 2001; 35: 188-196.[DOI]
[34] Batchelder L, Brosnan M, Ashwin C. The development and validation of the empathy components questionnaire (ECQ). *PLoS One*, 2017; 12: e0169185.[DOI]
[35] Hojat M. Empathy in health professions education and patient care. Springer Cham: Basel, Switzerland, 2016. [DOI]
[36] Kunyk D, Olson JK. Clarification of conceptualizations of empathy. *J Adv Nurs*, 2001; 35: 317325.[DOI]
[37] Wu Y. Empathy in nurse-patient interaction: a conversation analysis. *BMC Nurs*, 2021; 20: 1-6.[DOI]
[38] Moudatsou M, Stavropoulou A, Philalithis A et al. The role of empathy in health and social care professionals. *Healthcare*, 2020; 8: 26.[DOI]
[39] Lelorain S, Brédart A, Dolbeault S et al. A systematic review of the associations between empathy measures and patient outcomes in cancer care. *Psycho-Oncology*, 2012; 21: 1255-1264.[DOI]
[40] Miao C, Liu C, Zhou Y et al. Nurses' perspectives on professional self-concept and its influencing factors: A qualitative study. *BMC Nurs*, 2023; 23: 237.[DOI]
[41] Stavropoulou A, Kaba E, Obamwonyi VA et al. Defining nursing intimacy: Nurses' perceptions of intimacy. *Health Sci J*, 2012; 6: 479.
[42] Fry ST, Johnstone MJ, Fletcher M. Ethics in nursing practice: A guide to ethical decision making. *Can Nurs*, 2008; 99: 20.
[43] Thompson GN, McClement SE, Chochinov HM. How Respect and Kindness Experienced at the End of Life by Nursing Home Residents. *Can J Nurs Res Arch*, 2011; 96118.
[44] Koskenniemi J, Leino-Kilpi H, Puukka P et al. Respect and its associated factors as perceived by older patients. *J Clin Nurs*, 2019; 28: 3848-3857.[DOI]
[45] Shattell M. Nurse–patient interaction: a review of the literature. *J Clin Nurs*, 2004; 13: 714-722.[DOI]
[46] Halldorsdottir S. The dynamics of the nurse–patient relationship: Introduction of a synthesized theory from the patient's perspective. *Scand J Caring Sci*, 2008; 22: 643-652.[DOI]
[47] Mok E. Chiu PC. Nurse–patient relationships in palliative care. *J Adv Nurs*, 2004; 48: 475-483.[DOI]
[48] Kahn SA, Iannuzzi JC, Stassen NA et al. Measuring satisfaction: factors that drive hospital consumer assessment of healthcare providers and systems survey responses in a trauma and acute care surgery population. *Am Surgeon*, 2015; 81: 537-543.[DOI]
[49] Beach MC, Sugarman J, Johnson RL et al. Do patients treated with dignity report higher satisfaction, adherence, and receipt of preventive care?. *Ann Fam Med*, 2005; 3: 331-338.[DOI]
[50] Blanchard J, Lurie N. RESPECT: Patient reports of disrespect in The healthcare setting and its impact on care. *J Fam Practice*, 2004; 53: 721-731.
[51] Clucas C, Claire LS. Influence of patients' self-respect on their experience of feeling respected in doctor–patient interactions. *Psychol Health Med*, 2011, 16: 166-177.[DOI]
[52] Negarandeh R, Oskouie F, Ahmadi F et al. The meaning of patient advocacy for Iranian nurses. *Nurs Ethics*, 2008, 15: 457-467.[DOI]
[53] Murt MF. A concept analysis of power. *Nurs Forum*, 2020; 55: 737-743.[DOI]
[54] Campbell CD, Gordon MC. Acknowledging the inevitable: Understanding multiple relationships in rural practice. *Prof Psychol-Res Pr*, 2003; 34: 430.[DOI]
[55] Baptista MKS, Santos RM, Costa LMC et al. The power in the nurse-patient relationship: integrative review. *Rev Bioética*, 2018; 26: 556-566.[DOI]
[56] Sepasi RR, Abbaszadeh A, Borhani F et al. Nurses' perceptions of the concept of power in nursing: A qualitative

research. *J Clin Diagn Res*, 2016; 10: LC10.[DOI]

[57] Oudshoorn A. Power and empowerment: critical concepts in the nurse–client relationship. *Contemp Nurse*, 2005; 20: 57-66.[DOI]

[58] Hewitt-Taylor J. Challenging the balance of power: patient empowerment. *Nurs Stand*, 2004; 18: 33.[DOI]

[59] Leslie JL, Lonneman W. Promoting trust in the registered nurse-patient relationship. *Home Healthc Now*, 2016; 34: 38-42.[DOI]

[60] Dinç L, Gastmans C. Trust in nurse–patient relationships: A literature review. *Nurs Ethics*, 2013; 20: 501-516.[DOI]

[61] Bell L, Duffy A. A concept analysis of nurse–patient trust. *Brit J Nurs*, 2009; 18: 46-51.[DOI]

[62] American Nurses Association. (2023). Nurse-Patient Relationship — Importance of Trust. Available at:[Web]

[63] Halldorsdottir S. The dynamics of the nurse–patient relationship: introduction of a synthesized theory from the patient's perspective. *Scand J Caring Sci*, 2008; 22: 643-652.[DOI]

[64] Dinç L, Gastmans C. Trust in nurse–patient relationships: A literature review. *Nurs Ethics*, 2013; 20: 501-516.[DOI]

[65] Benkert R, Hollie B, Nordstrom CK et al. Trust, mistrust, racial identity and patient satisfaction in urban African American primary care patients of nurse practitioners. *J Nurs Scholarship*, 2009; 41: 211-219.[DOI]

[66] Çoşkun Palaz S, Kayacan S. The relationship between the level of trust in nurses and nursing care quality perceptions of patients treated for Covid-19. *Scand J Caring Sci*, 2023; 37: 364-372.[DOI]

[67] Langley GC, Klopper H. Trust as a foundation for the therapeutic intervention for patients with borderline personality disorder. *J Psychiatr Ment Hlt*, 2005; 12: 23-32.[DOI]

[68] Wadell K, Skärsäter I. Nurses'experiences of Caring for Patients with a Dual Diagnosis of Depression and Alcohol Abuse in A General Psychiatric Setting. *Issues Ment Health N*, 2007; 28: 1125-1140.[DOI]

[69] Donnelly F, Wiechula R. The lived experience of a tracheostomy tube change: a phenomenological study. *J Clin Nurs*, 2006; 15: 1115-1122.[DOI]

[70] Rask M, Brunt D. Verbal and social interactions in the nurse–patient relationship in forensic psychiatric nursing care: A model and its philosophical and theoretical foundation. *Nurs Inq*, 2007; 14: 169-176.[DOI]

[71] Alosaimi DN, Ahmad MM. The challenges of cultural competency among expatriate nurses working in Kingdom of Saudi Arabia. *Res Theor Nurs Pract*, 2016; 30: 302-319.[DOI]

[72] Sidumo EM, Ehlers VJ, Hattingh SP. Cultural knowledge of non-Muslim nurses working in Saudi Arabian obstetric units. *Curationis*, 2010; 33: 48-55.[DOI]

[73] Almutairi A, McCarthy AA multicultural nursing workforce and cultural perspectives in Saudi Arabia: An overview. *J Transcult Nurs*, 2012; 3: 71-74.[DOI]

[74] Al-Saggaf Y, Williamson K. Online communities in Saudi Arabia: Evaluating the impact on culture through online semi-structured interviews. Forum Qualitative Sozialforschung/ Forum: Qualitative Social Research. 2004; 5.

[75] Guha M. Saudi Arabia and the Gulf States Today: An Encyclopedia of Life in the Arab States. *Ref Rev*, 2010; 24: 66-68.[DOI]

[76] Gannon MJ, Pillai R. Understanding global cultures: Metaphorical journeys through 29 nations, clusters of nations, continents, and diversity. Sage: Newcastle upon Tyne, UK, 2010.[DOI]

[77] Halligan P. Caring for patients of Islamic denomination: critical care nurses' experiences in Saudi Arabia. *J Clin Nurs*, 2006; 15: 1565-1573.[DOI]

[78] Al-Shahri MZ. Culturally sensitive caring for Saudi patients. *J Transcult Nurs*, 2002; 13: 133-138.[DOI]

[79] Almutairi A F, McCarthy A, Gardner G E. Understanding cultural competence in a multicultural nursing workforce: Registered nurses' experience in Saudi Arabia. *J Transcult Nurs*, 2015; 26: 16-23.[DOI]

[80] Betancourt JR, Green AR, Carrillo JE et al. Cultural competence and health care disparities: key perspectives and trends. *Health Affair*, 2005; 24: 499-505.[DOI]

[81] Suh EE. The model of cultural competence through an evolutionary concept analysis. *J Transcult Nurs*, 2004; 15: 93-102.[DOI]

[82] Albagawi B. Examining barriers and facilitators to effective nurse-patient communication within a Saudi Arabic cultural context. Melbourne, RMIT University, 2014.

[83] Atallah MA, Hamdan-Mansour AM, Al-Sayed MM et al. Patients' satisfaction with the quality of nursing care provided: The S audi experience. *Int J Nurs Pract*, 2013; 19: 584-590.[DOI]

[84] Alahmmari AY, DipOdp BSN. Exploring cultural barriers to effective communication between expatriate nurses and patients in the Kingdom of Saudi Arabia. Melbourne, Monash University, 2016.[DOI]

[85] Karout N, Abdelaziz SH, Goda M et al. Cultural diversity: a qualitative study on Saudi Arabian women's experience and perception of maternal health services. *J Nurs Educ Pract*, 2013; 3: 172-182.[DOI]

[86] Banaser M, Stoddart K, Cunningham N. A qualitative study of patient satisfaction in oncology wards setting in Saudi Arabia. *J Nurs Health Sci*, 2017; 3: 85-97.[DOI]

[87] Strandås M, Bondas T. The nurse–patient relationship as a story of health enhancement in community care: A meta-ethnography. *J Adv Nurs*, 2018; 74: 11-22.[DOI]

[88] Lawrence P, Rozmus C. Culturally sensitive care of the Muslim patient. *J Transcult Nurs*, 2001; 12: 228-233.[DOI]

[89] Friedland R, Mohr J. The cultural turn in American sociology. Matters of culture: Cultural sociology in practice, 2004: 1-68.

[90] Akmajian A, Farmer AK, Bickmore L et al. Linguistics: An introduction to language and communication. MIT press: New England, USA, 2017.[DOI]

[91] Fakhr-Movahedi A, Rahnavard Z, Salsali M et al. Exploring nurse's communicative role in nurse-patient relations: A qualitative study. *J Caring Sci*, 2016; 5: 267.[DOI]

[92] Belcher M, Jones LK. Graduate nurses' experiences of developing trust in the nurse–patient relationship. *Contemp*

Nurse, 2009; 31: 142-152.[DOI]

[93] Mebrouk J. Perception of nursing care: views of Saudi Arabian female nurses. *Contemp Nurse*, 2008; 28: 149-161.[DOI]

[94] Van Rooyen D, Telford-Smith CD, Strümpher J. Nursing in Saudi Arabia: Reflections on the experiences of South African nurses. *Health Sa Gesondheid*, 2010; 15.[DOI]

[95] Alshammari M, Duff J, Guilhermino M. Barriers to nurse–patient communication in Saudi Arabia: an integrative review. *BMC Nurs*, 2019; 18: 1-10.[DOI]

[96] Ali AKM. Pre-Departure Orientation Programme: Study of Good Practices in Asia: A Comparative Study of Bangladesh, The Philippines and Sri Lanka. Labour Migration, 2005: 85.

[97] Al-Yateem N, Hijazi H, Saifan AR et al. Quality and safety issue: language barriers in healthcare, a qualitative study of non-Arab healthcare practitioners caring for Arabic patients in the UAE. *BMJ Open*, 2023; 13: e076326.[DOI]

[98] Baig N, Isgandarova N. Exploring Islamic Spiritual Care: What Is in a Name. *Religions*, 2023; 14: 1256.[DOI]