Patterns of Social Interaction and Lifeways which Affect Health and Healthcare of Families in Saudi Arabia and the Gulf States

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Abstract

Background: Lifeways of Saudi Arabia and neighboring Gulf States form a unique pattern. A large portion of healthcare providers are foreign nationals.

Purpose: The absence of insight into these unique lifeways by healthcare providers may limit their caring activities. Review of related literature has suggested that dissonance between clients and care providers may be a barrier to care.

Method: Purnell's Cultural Competency framework was utilized to focus on communication, family roles and organization, developmental tasks, social status, family dynamics, workforce issues, biocultural ecology, high-risk behavior, physical activity, nutrition, pregnancy, fertility, birth, spirituality, and death from the standpoint of healthcare delivery.

Results: Each of the sectors discussed illuminate important ways in which Saudi and Gulf society are similar and different from the body of research related to this area.

Conclusion: This inquiry has added perspectives which may be useful for provision of care by healthcare practitioners who are unfamiliar with some of the health related lifeways in Saudi Arabia and Gulf.

Keywords: Lifeways; Health; Healthcare; Families; Gulf-States

Introduction

Each society is marked by unique characteristics and lifeways which affect the way individuals within those societies address their needs for health care. A comprehensive discussion of lifeways particular to Saudi Arabia and Gulf States and effect of these habits on health care, has not yet been made available to the healthcare community. A number of lifeways which are practiced have important implications in the care of this population and insight into these patterns may assist in improving care by healthcare providers of all types.

According to Meleis in 2012, uniqueness may encourage us to consider the diversity and individuality of societies of interest, while at the same time seeking to apply what we know from the overall body of knowledge about caring (1). This body of knowledge may assist in understanding patterns of social interaction in Saudi Arabia and Gulf States of Bahrain, Kuwait, Qatar, United Arab Emirates, and Oman where lifeways form a single similar pattern (2). Although the need for information about caring for this population has been supported by studies cited in this inquiry, little has been found which offer useful guidance. A comprehensive discussion of Gulf States lifeways which relate to health consumption may assist healthcare providers in that locale.

Materials and Methods

Purnell, uses a theoretical model in analysis which may guide readers toward ways of providing care for Gulf States clients. It may also be helpful in providing a practical model for observing other cultures and locales for the purpose of improving healthcare delivery (3). The Purnell Model for Cultural Competence displayed in Appendix A provides a framework for viewing and assessing patterns of healthcare needs and consumption of any chosen culture or group and was therefore chosen as a lens for viewing Gulf culture (3).

This review includes search of available sources from online search engines such as Pubmed and Pubmed Central which list certain journals and sources which are not available from Web of Knowledge and EBSCO. This search resulted in a comprehensive bibliography of the focus sectors in the Purnell Model as follows.

Results

Overview/heritage

The overwhelmingly strongest element of Gulf culture is the Islamic faith (4,5). Mediated by patterns of social interaction of a primarily tribal pastoral desert dwelling society, religion is the basis for all activities including health behavior (4,5,6).

Muslims are encouraged to seek treatment and medical care. Islamic teachings promote moderate eating, consumption of hygienically prepared foods, regular exercise, and avoidance of alcohol, tobacco, or recreational drug use. Strict standards for personal hygiene as codified by the Hadith contribute to positive attitudes toward cleanliness.
Due to Bambia, Faiz, and Boughanem, three large urban centers in Saudi Arabia account for 85% of the population, with similar demographic patterns in the other Gulf States (7). This area of the world is strongly influenced by tribal origin, although there are also large communities of immigrants (8). Each tribal person is aware of their tribal origin.

The ideal marriage is a life-long relationship although a divorce rate of 21% is reported in mass media (9). Marriage within the tribe is the ideal. It is a civil contract and cousin marriage is the most desirable (8,10). The most preferred residence is a villa which describes a detached or semi-detached housing unit, regardless of size. Urban sprawl causes long journeys for patients to healthcare venues.
According to UNICEF, Adult (15 years+) literacy rate in Saudi Arabia is 87% (11). Nearly 5 million students are enrolled in gender segregated Saudi schools and universities (8,12). Healthcare providers find widely varying levels of literacy and health literacy among healthcare consumers. This variety of education competency should be considered when forming care plans.

Communication

According to Burnham, Saudi Arabia and GCC countries have highly up-to-date internet and telephone systems (13). A poll in 2003 found that two thirds of Saudi citizens have access to the internet (14). Additionally, according to Assad, influx of oil wealth and increased communication with other cultures has influenced individual priorities and lifestyle, pushing materialism forward (15).

Healthcare providers need to be aware of the etiquette, style, and character of communication. During establishment of rapport with clients correct naming is essential and may be complicated; each person having four names; women using their birth name, and high levels of duplication. These patterns can have major implications for healthcare providers and care must be taken to avoid accidents which could potentially affect client health and safety.

Communication Context

Communication style is high-context. Because of this members are able to understand messages with less explanation and more innuendo and implicit references (16,17). High-context communication is characterized by avoidance of interpersonal conflict and this is true of social interaction in this area. According to Almutairi and McCarthy, group consensus is of higher value than individual expression (18). Healthcare providers must also be cautious about power differentials which may alter communication between themselves and their clientele and interpersonal communication between clients and client groups.

Non-verbal Communication and Etiquette
Use of hands in talking is common and a set of gestures is well understood. Males stand quite close to each other, as do females but when a male and female are interacting, the personal space is quite expansive and no touching occurs. Al-Shahri, stated that healthcare professionals may find that clients of the opposite sex do not wish to be touched by them although they are reluctant to express this feeling (19). Every effort should be made to have a same sex professional available especially if care involves touching (17,19).

Men and women who are not related by birth do not generally engage in social conversation in public. Even in a professional setting it is not uncommon for female clients to communicate to male healthcare providers through a male proxy who has accompanied her. Male healthcare providers are strictly advised to avoid interviewing or examining any female client unless she is accompanied by her male proxy and preferably also a female staff member (16). Parameters of polite conversation may vary between social groups and this may be a source of dissonance (4,10).

Another important aspect of communication is “face”. Saudi and Gulf societies are tribal, high-context, and relatively small. Therefore, members of society are familiar with each other’s social position. Those with more “face” may receive preference. Housemaids and migrant laborers may receive more comprehensive care when accompanied by their employer because of this dynamic. Shame is a concept which is deeply entrenched. Activities which are either morally unacceptable or simply bad manners may cause this. Honor is a stronger concept in weighing behavior. Loss of honor is caused by violation of law or moral percept. Awareness of parameters of social interaction is of vital importance in societies of all types but is particularly essential when personal interactions are highly circumscribed by tenets and codes. Emphasis on awareness of social climate should be part of orientation of all healthcare professionals.

Family Roles and Organization
According to Kalu, Saudi society is very patriarchal (21). A senior male is responsible socially and legally for the welfare, health, care, and behavior members of all ages in the household (20,21); they are also legally responsible for other persons such as aged parents, and widowed or divorced sisters and aunts who may or may not live in the household. Women do not customarily live alone (22). Ratner and El-Badwi, argue that the legal and civil matters for female relatives often require his assistance (23). Healthcare providers need to consider the pressures, stresses, and demands which are carried by the head of large families in all phases of care planning.

While the male head traditionally holds responsibility for the extended family, women bear responsibility for the welfare of all within the home including management and developmental tasks. Employed women who comprise 22% of all adult women have the double burden of household and workplace responsibilities (7). Consequently, the housewife is a skillful micro-administrator.

In addition, several studies argued that the living arrangements vary but the norm is that family always comes first. The concept of family to Saudis and members of the Gulf States describes nuclear or extended family, and tribe which provide support for each other (10,12,24). Being a collectivistic society, consensus, hospitality, generosity, and honor are highly valued over individuality and non-conformity (9). In addition, Alhamidi stated that a mixed methods inquiry found that consensus and hospitality of guests had priority over providing healthy dietary choices for children, perhaps contributing to childhood obesity (8).

Since religion is the basis for the social system and norms the best available way to gain a perspective on ideal family relations is to consult the Quran and Hadith. A healthcare provider who depends on this source will not go wrong.

Dress
Most practices in Gulf society are dictated by religious or tribal principles. A highly visible example of this construct is dress. Female sexual chastity and modesty are part of family honor and influences the style of dress. Men are less restricted but also are subject to certain strictures. Further, tribal traditions such as veiling of the face have taken on a religious aspect and are incorporated into the code of expected dress by many. Often this restricts exercise options. Healthcare providers should be aware of this aspect of dress when forming a care plan, for example, recommendation for physical exercise (8,2).

Gender Segregation
Another construct which has received conservative interpretation is public mixing of gender. Due to Almutairi and McCarthy, stated that the health practitioners in Saudi Arabia need to bear in mind the necessity of providing same gender care although in cases of need this principle may be bypassed (18). Separate facilities such as vital signs rooms, physical therapy, and phlebotomy suites need to be provided since a certain amount of disrobement may be required.

Developmental Tasks
The major person in children’s lives is the mother. While men are expected to be the economic pillar of the family, the mother is expected to bear responsibility for education, social, and health care of her children. Maternal grandmothers are especially influential. This is reinforced by the segregation by gender which characterizes all educational, social, and health institutions (12).

Health care providers for young children up to about the age of ten, usually are in contact with mothers, or a grandmother. However, when major health events are being planned – such as surgery or travel to a referral center, fathers and mothers must be included. This is especially true of mothers who are not literate or living in urban areas. Special efforts must be made to involve the male proxy when interviewing or treating young children if the healthcare professional is a male (8).

Social Status
Saudi society bases class on a variety of criteria. These criteria interact. Attributes in one criteria mediate the effect of other characteristics which are part of the formula. Tribal membership is an important element in social status. Individuals who are of tribal origin have higher status in some regions of the Gulf. Intermarriage between tribal members and members of other tribes is the ideal (7). However, the tribal system is weak in some regions such as coastal areas. Lineage which can be traced back to Prophet Mohammed (pbuh) is used to designate elevated status in Hejaz, the Western area of Saudi Arabia.

In addition to tribal status, education, wealth, and religiosity are mediating factors. For example, a person from a distinguished tribe may be considered lower-class if the lifestyle they pursue violates social norms, while a religious or highly educated person, can be highly regarded and elevated in class (16). Merchants, religious scholars, distinguished intellectuals and professionals mainly form the upper-middle or middle class. This status is conferred on the individual and his nuclear family but not his or her extended family. Therefore, any individual may have a variety of social statuses within the extended family (2).
The construct of "nas" is useful for understanding social structure. One who is elevated in status is referred to as "walid nas" or "bint nas" meaning son or daughter of "people". This evaluation can vary depending on the status of the evaluator and usually implies that the person in question is at or above the status of the speaker. It is therefore a very flexible concept.

The use of social status is important in access to resources (11). Because this is a high-context society, social influence as a determinant of distribution of resources is common (8).

Socially well placed members of tribes or families are very frequently requested to intervene on the behalf of a lower status member for the purpose of access to services and socially mediated resources including health care. Healthcare providers should be aware of these dynamics in social structure. Access to specialized medical care is frequently obtained in this way and should be considered as a resource during assessment, diagnosis and care planning.

Family Dynamics
There are happy households where relationships are harmonious and others where they are not. Healthcare providers will find many varieties and qualities of relationships in practice. Unfortunately, empirical reports concerning family relations were not found in the literature (25).

Moreover, several studies indicated that the healthcare providers should avoid stereotyping family dynamics and social standing but instead perform as thorough an assessment as possible before forming a diagnosis and care plan. Professional ethical practices such as individualization, self-awareness, non-judgmental attitude, empathy, and avoidance of stereotyping assist healthcare professionals to assess, diagnose, and navigate client needs based on individual family dynamics (4,6,12,26).

Workforce Issues
The migrant work population which constitutes about one-third of the population is drawn from extremely diverse lifestyles and cultures. Many are from the poorest segments of their home countries. Although required to meet certain health standards to obtain a work visa, it is mainly for the protection of the local population and not an indication of general good health. Therefore, healthcare providers are caring for an extremely diverse group of clients who may have important health problems (27).

Caring for the Healthcare Workforce
Healthcare providers are also a diverse group. The vast majority of healthcare providers who are in direct contact with clients are foreign. They are mainly drawn from the Philippines, India, Egypt, Jordan, South Africa, Uganda, the United Kingdom, and the United States. Each of these groups bring their own culture to the workplace. Between the years 2000 and 2008 a total of 53,771 Philippine nurses began employment in Saudi Arabia (28).

In addition to the learning about Saudi culture and language these workers need to learn about each other (8,28). Difficulties are encountered with patient care and communication between patients and staff and between staff members. In a cross-sectional study of burnout syndrome among Saudi and non-Saudi nurses levels of emotional exhaustion were significantly higher ($p=0.004$) among the non-Saudi nurses than the Saudis (29).

In a review of 8 studies which inquired into key issues, problems, barriers, and challenges in university hospitals in Saudi Arabia it was concluded that improvement in patient safety, clinical effectiveness, and patient-centeredness were important problems in delivering quality client care and were especially exacerbated by lack of instruction and effective communication between clients and healthcare staff (27)

Nursing education must prepare local graduate nurses from the variety of ethnic groups within the Gulf to assess and diagnose client and community needs effectively. Cultural competency skills should be included in the nursing curriculum. Orientation and training of the multicultural, multinational workforce which now characterizes the healthcare team in the Gulf must be well planned. The healthcare professionals from the huge variety of ethnic origins require culturally competent training. Indigenous healthcare professionals are well suited for this purpose but must be appropriately prepared for the task themselves with training in pedagogy.

Bio-cultural Ecology
Added to the gene pool of original tribal groups are influences from immigrant migration and trade. According to Abo-Amero et al, analysis of mitochondrial DNA from buccal swabs of 120 maternally unrelated Saudis who gave histories of having ancestors of Saudi Arabian origin found that 85% of the lineages are of western Asian origin while Sub-Saharan Africa, North-African, and Indian influence was found to be 7%, 5%, and 3% respectively (30).

Consanguinity is quite intense because of the popularity of marriage within the family. In a sample 3212 Saudis in a cross-sectional random stratified study an overall rate of 57.7% consanguinity was found including 28.4%, 15.2%, and 14.6% marriages involving first cousin, distant relative, and second cousin marriages respectively. In other Gulf States the rate of consanguinity is nearly identical (22,31).

Implications for healthcare providers relies on patient education. Considering the rate of congenital defects in the population, and the limits on abortion, control of birth defects through genetic counseling may need to be addressed. Therefore, pre-marital screening to identify carrier states and counseling, public education, and establishment of a national registry and mutational database seems to constitute best practice for this area of the world (1,17,22).

High Risk Behaviors

High risk behavior occurs but because of the conservative nature of the social structure, information about these practices is highly limited. Access to treatment may be complicated by social, legal, and religious implications for clientele. Therefore the incidence of these behaviors are considered to be highly under-reported (32).

Use of Tobacco

From a conservative social point of view tobacco smoking or use in Gulf States is frowned upon. Tobacco is used via cigarettes or water pipe. Water pipe has been found to produce similar levels of nicotine dependence as other forms of tobacco (33). In a cross-sectional study of 1,652 Saudi secondary school students it was found to be the form of consumption for 54% of the 30.3% and 8.5% females who are smokers in Al-Hassa (29,34).

Use of Alcohol

According to Haqwi, alcohol consumption is strictly prohibited by Islam and therefore is strongly rejected by the norms of society (35). Sale, production, or consumption of alcohol is illegal in Saudi Arabia and Kuwait. Alcohol is sold on a limited basis to expatriates and at tourist venues throughout other Gulf States. However, in Ha'il 7.5% of a group of respondents in a cross-sectional convenience sample collected among volunteers in schools, health centers, and shopping venues reported consuming alcohol (36).

Other Illegal Substance Abuse

Due to Fageeh, trafficking in illegal drugs in any capacity carries a death sentence. However, cannabis, cocaine, and heroin are present, although at low levels (37). Additionally, according to World Health Organization (38), a drug locally known as Captagon, the local name for fenethylline, a synthetic amphetamine, is abused by youth to pursue a lifestyle of night life, during exam time, and among truck drivers (39,40).

Khat is illegally grown locally and also smuggled from Yemen. In a cross-sectional study self-administered questionnaire of 10,000 college and secondary school students in Jazan Province consumption was 21.4%. A gender difference existed with 3.8% and 37.7% of females and males respectively being Khat users (41).

Sexually Transmitted Infections

Information regarding incidence of sexually transmitted infections (STI) is difficult to access. Non-marital sexual relations and homosexuality are prohibited and illegal limiting information. As of 2005 gonococcal urethritis, syphilis, and HIV accounted for 14.2%, 8.7%, and 7.5% of reported STI cases respectively. Male expatriates accounted for two thirds of reported cases of HIV (36).

Implications for healthcare providers in assessing high risk behaviors should include a high level of awareness. Gulf society requires visible behavior to conform to ideals, laws, and beliefs. Clients may not report behavior. Intuitive and objective client assessment is therefore highly important.

Road Traffic Accidents

Saudi Arabia has the worldwide highest incidence of road traffic deaths and spinal cord injuries (42). Among deaths in public hospitals 81% result from traffic accidents, occupying 20% of the total bed census and accounting for the majority of maxillofacial fractures in Saudi Arabia (43, 44).

Physical Activity

Sedentary lifestyle is related to unfavorable weather conditions making out-of-doors exercise impractical (45). Walking for pleasure is not an important part of the local social structure. The urban built environment is not well designed for pursuit of outdoor exercise.

It is not surprising that less than 50% of boys, aged 7-11 years, reported that they participate in moderate physical exercise. Adults report any exercising as 19% and 0.5% respectively for males and females (46,47).

Nutrition

Badran and Laher, profess that food choices have been changing (47). A traditional diet based on whole grains, fermented milk, and dates is being displaced by rice, meat, convenience and fast food. Whereas feasting was limited to special occasions such as weddings and births in the past, it is now common as week-end entertainment, causing concern to investigators (46,48).

Obesity in the Gulf Countries

Increasing body weight is causing alarm from healthcare providers (49,50,51). Large systematic reviews and meta-analyses are not yet available to define this problem. However, a meta-analysis of adults aged 30-60 years in Kuwait, Qatar, and Saudi Arabia found the obesity rate among men and women ranged from 70-85%, and 75-88% respectively with being overweight and obese were 21.5% and 13.7% respectively among children (52,53). Due to Alhamidi, low levels of activity, priority of family social lifestyle, ready availability of obesogenic foods, and intrafamily patterns of interaction and discipline were found to affect the obesogenic environment in Saudi homes (4,8).

Significance of Food
Food is used as a means for giving and receiving status. The ultimate food offered to guests is a whole sheep. This pattern of use of food for social purposes has implications for clients who must adhere to special diets. Counseling, role play, and mentoring may be helpful in meeting challenges for these clients (4,8).

Pregnancy, fertility, and birth
Children are considered a vital part of life. Index Mundi, referencing the CIA World Factbook, projects the total fertility rate in 2016 to be 2.11 children per woman. Children under 14 years and elderly (65 years +) constitute 60% and 3% respectively (54).

Infertility poses a threat to marriage. Divorce or polygyny may be an outcome. Treatment for infertility is not restricted to childless couples and many high tech possibilities to enhance fertility are available in the Gulf. Potentially harmful procedures by traditional healers may also be employed by many as a last resort to produce offspring.

Pregnancy is not considered a delicate condition and pre-pregnancy health status is expected to continue during pregnancy. Additionally, according to UNICEF, 2014, women continue to fulfill all of their familial and household duties. Home birth is not popular and hospital delivery occurred at the rate of 97% in Saudi Arabia in 2015 (42). Postpartum care instruction occurs just before discharge of the new mother from the hospital. Breast-feeding instruction is not practiced. Upon discharge mother and baby traditionally reside with the maternal grandmother for a period of 40 days. All normal activities are resumed at the end of this period.

Contraception
Among a sample of 502 participants attending government funded primary health care centers in the Qassim area, those women who are older, working, more educated, and grand multipara are more likely to use contraception while less educated, lower income, and having a higher proportion of female children have narrower spacing. Overall, users of some form of contraception numbered 44.8% (55). Among 786 ever-married women the average time between deliveries was 2.38 years (56).

There are a multitude of implications for best practice during pre-pregnancy, pregnancy, delivery, and postpartum. Culturally competent health promotion efforts are needed for all stages of perinatal care. This begins with appropriate assessment, diagnosis, planning, implementation and evaluation of social interaction patterns and available resources in order to guide design of programs which are culturally congruent, attractive, and accessible to stakeholders and target population as a whole (4,5).

Death
Based on the interpretation of the Holy Quran, the correct approach to illness is a search for improvement or cure. In a qualitative study of 284 Muslims near death three important domains were found to be important concerns: faith and belief, self-esteem and image related to their behavior and appearance at the time of death. Security of remaining family also emerged as an important theme (44).

In a cross sectional convenience study conducted by Mani and Ibrahim, intensive care unit (ICU) nursing staff role were studied and a wide gap existed between concept of the role and method of the caring process at the end of life among professional caring staff and family members of patients (57). This gap needs to be addressed by education accompanied by a formulation of end-of-life care policy in ICUs which is in agreement with culture and belief among the Saudi population.

The expressed goal of the healthcare community care is preventative or curative in the Gulf States with palliative care not being a well-developed concept. Pre-morbid directives popular in the West are not popular among health care professionals or the community at large (27).

In a cross-sectional study 98% of oncology patients stated that they preferred being fully informed about their diagnosis whereas 92% of their physicians agreed. These results point to a potential failure to meet communication needs of patients and their families (58).

Breaking bad news to patients is problematic finding that 10% and 5.15% of physicians employed in hospital and primary care respectively agreed to the statement “I usually avoid telling my patients about their final diagnosis” and 46.6% of the physicians employed in hospitals agreed with the statement: “The patient always has the right to know his/her diagnosis” (59).

Spirituality
The main basis of Gulf society is the Islamic faith with interpretation by a generally conservative point of view, and further mediated by tribal customs. This forms a unique blend which characterizes the area’s spirituality (19,57).

Implications for healthcare providers are the application of non-judgmental caring accompanied by good knowledge levels about religious beliefs and practices of the target group, self-awareness, and empathy. Nurses need to be aware of their own comfort level in providing spiritual care and to understand the level of spiritual need of the patient and caregiver. This individualization enables the nurse to plan for delivery of systematic spiritual care from a variety of available sources within and outside the healthcare community (60).

Healthcare Practices
Care of one’s body and health is considered a right of the living body which the soul inhabits (46,60). Use of physicians and medicines to treat illness is religiously encouraged. When Prophet Mohammed (pbuh) was asked about medical care he replied: “Yes, you should seek medical treatment, because Allah, the Exalted, has let no disease exist without providing for its cure, except for one ailment, namely, old age” (61).

Health Locus of Control

Health locus of control (HLC) in the Gulf has been found to be influenced by several factors. Until very recently curative rather than preventative care has been the focus of the health system (46,61). Preventative care remains secondary to administration of primary care. This atmosphere requires the client to have a high internal HLC and strong general self-efficacy due to the obstacles met in the health care system in the pursuit of this goal (61).

Traditional Healing Practices

Traditional healing has an important place in health care among the people of the Gulf. The use of traditional practices is used before, after, or concurrently with conventional health care.

Based on the WHO cluster sampling method, 462 families were assessed using a structured questionnaire to determine the patterns of utilization of traditional medicine. Belief in the effectiveness of traditional medicine was expressed by 51% of clientele but was actually used after failure of conventional treatment by 25% of the group studied. Elderly, female, and illiterate clients are more likely to use traditional healers than other groups. Among clients surveyed, 42% had ever consulted a traditional healer at some time with 24% having done so within the past 24 months (62).

Clients may use a variety of non-conventional treatments which are not considered to be traditional Saudi healing. They are often costly and not yet regulated. The Council of Ministers has approved a center responsible for establishing rules, criteria, conditions, and licensing of these practitioners (37).

Healthcare providers must become familiar with the traditional healing practices and beliefs of the target population. These may vary between ethnic groups in the Gulf area, but because of the high incidence of use among the client populations, knowledge about and sensitivity to these beliefs and practices may have a major impact on care.

Mental Health

About half (50%) of primary care patients studied blamed nerves, stress, and religious factors as a cause for their physical symptoms so that the effect of mental and emotional factors on illness is recognized by the population (63). However, mental health is not freely discussed, and at times even immediate family members are unaware that this type of care is being used by the client. Punishment by God is considered one source of disturbed mental health. Supernatural forces such as witchcraft and evil eye are used to account for other types of conditions by clientele (64). Awareness of this attitude is important because clients are not likely to freely request care for mental health problems from their healthcare practitioner.

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Conclusions and Limitations

By examining features of the target population perspectives may have been gained into the variety of lives of its people and their lifeways. There may be limitations in use of this analysis based on regional differences and practitioners will be well advised to employ this guide as a starting point in understanding healthcare needs and client characteristics. Common threads which run through the fabric of the Gulf States have been discussed giving the practitioner a starting point for considering the health care needs of the people living there and how best to address them.

Congruity of care priorities between healthcare professionals and clientele need exploration. In phenomenological descriptive collections of narrative gathered by six expatriate critical care nurses, the central themes which emerged from caring for Saudi clients were family and kinship, cultural and religious influences, and the nurse-patient relationship which was complicated by stressful and frustrating communication patterns (37,64). In ranking care priorities, clients ranked information, cultural, and spiritual needs as the dominant needs. Support and proximity were least important to them which may be easily understood because of the highly supportive patterns of social interaction between family members.

In a cross-sectional study using a self-administered questionnaire to inquire from 176 family members and 497 intensive care providers in adult medical-surgical units about the needs of families at the time of death, researchers found that looking for information, maintaining reassurance, spiritual healing, maintaining close proximity, and respect and care of the body of an expired family member were top concerns. While care of the remains of an expired family member was ranked in fifth priority by health providers it was the first concern of the family members studied. This dissonance of priorities between family members and staff suggests that much more effort may be needed in establishing a culturally competent environment for critical care patients and perhaps others (65).

Specific values are contained in the ANA Code of Ethics which have resulted in the concept of cultural competency byAmerican Nurses Association (66). The inherent dignity of the individual, autonomy and the right to self-determination are important concepts when caring for all clientele. Social work values such as empathy, confidentiality, self-awareness, client individualization, and non-judgmental attitude are also part of the values which nurses who wish to be effective in caring must work toward (67).

Evidence-based research and a sound knowledge based on needs of our target population must be coupled with values and ethics to form a powerful formula which can be used to provide culturally competent caring and best practices. When these elements are combined with specific language and lifeways training during pre-service and ongoing orientation programs, a comprehensive orientation for caring for culturally diverse clients emerges.

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Appendix A: The Purnell model for cultural competence: