Experiences of Arab Immigrant Women in Emergency Departments in Halifax Regional Municipality

by

Amel A. AlGallaf

Submitted in partial fulfillment of the requirements
for the degree of Master of Nursing

at

Dalhousie University
Halifax, Nova Scotia
August 2014

Table of Content

Abstract

This feminist phenomenological study explored the gendered experiences of Arab immigrant women when visiting Emergency Departments (EDs) in Halifax Regional Municipality (HRM), Nova Scotia, Canada. Six Arab immigrant women who visited EDs in HRM were recruited from the community. The purpose of the research was to provide a deeper understanding of this population while engaging with health care providers in EDs. Four themes emerged: Engagement in Cultural Care with Health Care Providers, Disengagement and Cultural Care, Suffering in Pain While Waiting, and I am lost! Help Me Please! Bringing these women's experiences to the attention of health care providers may assist in providing safe, ethical, culturally congruent, and equitable care. It also provides a basis for future studies which together may contribute to institutional policy development, best practice guidelines, and educational curricula. This may potentiate an improvement in this population of women’s health outcomes and a better quality of life.

Keywords: Arab immigrant women, Arab culture, phenomenology, feminism, embodiment

List of Abbreviations Used

ED: Emergency Department

EDs: Emergency Departments

HRM: Halifax Regional Municipality

PV: Per-Vaginal

US: United States

US HCS: United States Health Care System

NSDH: Nova Scotia Department of Health

CRRNS: College of Registered Nurses of Nova Scotia

ABNAC: Aboriginal Nurses Association of Canada

CASN: Canadian Association of Schools of Nursing

CNA: Canadian Nurses Association

CMA: Canadian Medical Association

ANA: American Nurses Association

ESL: English as a Second Language

PhD: Doctorate of Philosophy

Acknowledgments

This research could not have been completed without the continuous support, guidance, and expertise of my supervisor, Dr. Goldberg, who inspired me throughout my journey. Her insights, critical eye, and ongoing patience assisted me in developing an in-depth knowledge of feminist phenomenology as a methodology to guide this research. The support of my committee members, Dr. Chircop and Dr. Hamdan, cannot be overlooked. With expertise in women's studies and cultural diversity, Dr. Chircop's feedback offered robust insights that further enriched the study. Dr. Hamdan, as a Muslim feminist scholar, brought essential knowledge in the areas of Arab and Islamic feminism, further enriching the substantive and methodological areas of the research.

My family’s love and support offered additional motivation in assisting me throughout my journey. The emotional support of my parents, Fatimah Fahad and Ali AlGallaf, worked their magic, always offering comfort while my husband, Mohammed AlZawad, was with me every step of the way in encouraging me to complete this work.

The support and guidance from faculty members and staff in the School of Nursing further assisted me in my journey. They include, but are not limited to, Dr. Marilyn McDonald, Ms. Jackie Gilby, Dr. Donna Meagher-Stewart, Dr. Megan Aston, Dr. Audrey Steenbeek, and Dr. Nancy Edgecombe. I also take this opportunity to express my profound gratitude and deep appreciation to Dammam University and the Ministry of Higher Education in Saudi Arabia for their financial support, which greatly assisted me in completing my Master’s program.

Lastly, I would like to thank the Arab immigrant women who participated in the study and bravely shared their stories with me throughout the context of the research. Without their time, generosity, and support, this study would not have been completed.

Chapter One

Introduction

[Understanding women's] life experiences are valuable because they allow one to examine prior ways of being and present ways of becoming, as well as to reflect on the social [and cultural] contexts that influence these processes of being and becoming. (Qin, 2000, p. 75)

Understanding the Meaning of Arab Immigrant Women's Lived Experiences in Hospital Settings

Globalization has dramatically increased over the last few decades (Guruge et al., 2009; Leininger, 1996; Wall, 2007), resulting in multiculturalism and diversities (Festini et al., 2009; Leininger, 1991; Leininger, 1996; Leininger, 1999; Papadopoulos & Omeri, 2008; Wikberg & Eriksson, 2007). Despite the benefits associated with diversity and immigration, immigrants' experiences can be complex and stressful (Dastjerdi, Olson, & Ogilvie, 2012). This experience can be even more challenging when immigrants are sick and need medical attention.

The Arab immigrant community of women in Halifax, Nova Scotia, of which I am a member, is increasing rapidly (Statistics Canada, 2011). There are diverse countries from which Arab women originate, and many women don't speak English, leading to barriers in accessing health care. Understanding both overt and covert meanings in languages is of great importance when dealing with clients from diverse cultures (Papadopoulos & Omeri, 2008; Wikberg & Eriksson, 2007). In addition, some Arab women come from cultures that privilege men over women (Yount, 2005), where issues of inequities and power differences are taken for granted within the cultural fabric of that society (Canada and the World, 2012).

When Arab immigrant women access the Canadian health care system through EDs, health care providers may not be aware of their culturally specific needs, and Arab immigrant women may not be able to communicate their needs effectively or make decisions regarding their health. This may be the result of language and cultural barriers and/or due to disease processes. Further, this may also result from the fact that they previously accessed a male dominated health care system in their home countries where they did not have autonomy in relation to their decision-making. When Arab immigrant women express their cultural needs, some health care providers –as a result of cultural blindness ignore differences between patients and treat them all the same way. This can further result in labeling this population of immigrant women as “difficult” (Aboul-Enein & Aboul-Enein, 2010) entailing discriminatory health care practices. As such, Arab immigrant women may become more hesitant to access the Canadian health care system, which can lead to poor health outcomes for this population of women. These factors suggest Arab immigrant women may be more vulnerable to oppression and patriarchal hegemony, although currently there is less academic attention about how this population perceives Canadian culture, especially when they access Canadian hospitals.

Oppression and hegemony occur when a person uses her or his authority in unjustly and unfairly on another, and it is usually the dominant socio-cultural group who forces under-represented people to accept and follow the dominant way in these societies (Brookfield, 2009; Dong & Temple, 2011). The Canadian health care system presents a unique system that has gone through reforms and progress in order to ensure that it addresses the needs of its population in order to help people maintain and improve their health (Health Canada, 2014). This system is often looked upon favourably by others worldwide for its quality. For example, a study by Sanmartin and colleagues (2006) that compared the health care systems in Canada and the US, found that US citizens who had a lower socio-economic status had poorer health outcomes than Canadians. Yet, Canada has a high percentage of immigrants in its population (Kobayashi, Prus, & Lin, 2008), with about 250,000 immigrants with diverse cultural backgrounds from all over the world moving to Canada every year (Immigration Watch Canada, 2010). There is an urgent need for the Canadian health care system to address the uniqueness and diversity of its population(s) to ensure equitable health care is available for all of its population.

The Purpose and Research Questions

The purpose of this study is to explore the gendered experiences of Arab immigrant women in EDs in HRM, NS. This exploration is intended to contribute to a deeper understanding of their beliefs, values, attitudes, and views as well as their interactions with health care providers, specifically nurses who are the first line providers dealing with them in EDs in HRM. Findings from the research may offer potential for contributing to best practice guidelines, educational (nursing) curricula, and continuing education for health care providers working with Arab immigrant women in the context of emergency care.

Feminist phenomenology, discussed in the next chapter, was used to guide the analysis and interpretation of women's stories in the study; the following questions framed the research and were well aligned with this methodological approach:

1) How do Arab immigrant women describe their experiences in EDs in HRM, NS?

2) What kinds of support do Arab immigrant women receive when accessing the Canadian health care system through EDs in HRM?

3) What kinds of challenges do Arab immigrant women encounter when accessing the Canadian health care system through EDs in HRM?

4) What changes/modifications do Arab immigrant women believe are important to be incorporated into the system of EDs in HRM?

(See: Appendix A- Interview Questions Guide for more details)

Reflexivity: Coming to the Research Questions

Reflexivity is the ability of researchers to critically examine and analyze data and use it to understand their own underlying assumptions throughout the research process. This means that researchers are involved in consecutive self-appraisal throughout the research process, remaining aware of their influence own in the process (Dowling, 2006; Dowling, 2007; King, 1994; Wuest, 1994). Dowling (2006) claimed that reflexivity is the process of “self-inspection” and “self awareness” (p. 8), which in turn enhances the “consciousness of the researchers of the effects of the research process on the researcher's identity [and] the impact of the research on the subjects” (Wuest, 1994, p. 95). Hamdan (2009b) defined reflexivity as “researching [self] and reflecting on personal beliefs and values both as a researcher and as a member of the researched group” (p. 378). This entails including researchers' stories and backgrounds as a key part of the research (Hamdan, 2009b). Dowling (2006) and King (1994) argued that reflexivity plays a significant role in feminist research because it aims to have researchers' voices as a main part in the research through involvement of their experiences as women, and it emphasizes the relationship between participants and researchers.

As a nurse in Saudi Arabia, my home country, working in an emergency department for several years, I dealt with diverse people from different countries and different cultures who spoke languages other than Arabic. From this experience, I realized how challenging it could be to provide care when health care providers and patients could not communicate effectively with each other. Hence, I realized that an understanding of different cultures along with analysis of the experiences of people from different countries could help to alleviate the anxiety and the uncertainty associated with these diversities. Moreover, as an immigrant to Canada, I understand how uncomfortable the experience is when a person cannot interact effectively and cannot express and do things the way she/he was used to do in her/his home country.

As a patient in an emergency department (ED) in HRM, I had a challenging experience associated with my miscarriage four years ago. I had to wait for four hours before seeing a physician, which felt exhausting, especially as I was in physical and psychological pain. My experiences were different in my home country. In Saudi Arabia, if I was in a hurry and did not want to wait, I went to a private hospital and was treated at once. What is more, at the ED in HRM, there was not a female physician working during that shift, and a male physician wanted to do a physical examination, including a per-vaginal (PV) examination. In my culture, having male doctors examine women patients in these circumstances is not preferable, and a nurse did the PV examination for me. After this experience, I was thinking about other Arab immigrant women, especially those who cannot speak English or who are heavily dependent on their husbands or fathers, as they used to be in their home countries. I expect that their experiences would be even more challenging, and I became more interested in an in-depth understanding of their lived experiences when accessing the Canadian health care system through EDs in HRM.

As a nurse in the ED at the QEII during my clinical practicum in 2011, I observed that most of the Arabic-speaking patients who visited the ED appeared lost and did not know what to do or where to go. After a brief conversation with some of them, I realized that this challenge was due to a lack of understanding of the differences between the systems in their home countries and the Canadian health care system.

As a researcher doing a feminist phenomenological study, I was a key instrument in the research. My thoughts, experiences, beliefs, and values were reflected in the study (King, 1994; Mackey, 2005; Walters, 1995). This can enrich the research because I shared experiences that may also be shared by other Arab immigrant women. That is to say, I anticipated that being a woman from an Arab culture assisted me in gaining insight into their lived (gendered/cultural/historical) experiences and their challenges. I therefore might feel the same way they felt and/or have encountered similar challenges, which in turn could result in being more creative in suggesting suitable solutions to the identified problems and in making these solutions fit what would be preferable in Arab culture. In many ways I live what they live, and am more aware of their situation. My views and/or suggestions are not based on a perspective made by an outsider, a person with a different cultural background, who may not fully understand their experiences in their home countries. Moreover, my deep understanding of Arab culture helped me when analyzing the data collected from Arab immigrant women; I speak the same language and share the same culture, which facilitated the comprehension of hidden meanings within the context of the culture.

For the purpose of the research, I found that interpretive phenomenology resonated with me because of my interest in gaining a deeper understanding of the meaning of lived experiences and how these experiences are affected by the world tin which people live (Lopez & Wills, 2004; Mackey, 2005). Moreover, my curiosity has driven me to investigate the conditions of women in my culture in order to understand and assist them in overcoming the social oppression they might experience when living in a diverse culture. For example, after interviewing the participants and analyzing the data, the challenges that they encountered based on their lived experiences could then be communicated to policy makers in EDs in order to see what could be done to resolve these issues. A detailed explanation of feminist phenomenology and how the philosophical underpinnings fit with my worldview will follow in the forthcoming methodology chapter.

Literature Review: What is Currently Known and Gaps in Knowledge About the Experiences of Arab Immigrant Women in EDs in HRM

The literature review was conducted using books, academic journals, work done by agencies, and the following databases: Pubmed and Cochrane library, CINHAL, Ovid, Google scholar, ProQuest, theses and dissertation databases, and governmental websites. The following terms were used: *Arab immigrant women, Arab culture, Canadian health care system, Canadian hospitals, phenomenology, feminism, feminists, Arab women, Western culture, North American Hospitals*. English-language articles were selected. In the literature, there were no available studies found documenting the experiences of Arab immigrant women in any hospital setting, including EDs in HRM or elsewhere in Canada. Some studies explored the experiences of immigrant women in Canada generally, not specifically Arabs (Amaratunga, 2002; Higginbottom, Bell, Arsenault, & Pillay, 2012; O'Mahony & Donnelly, 2010). As a result, I extended the scope of my search to the experiences of Arab immigrant women in North American hospitals. Again, the results of my search were limited because a plethora of articles addressed the experiences of both Arab immigrant women and men with the United States Health Care System (US HCS).

In most of these gender-mixed studies, the number of women was less than half. On the Canadian governmental websites, there is no recent and accurate information and/or statistics of Arab women in Halifax or Arab immigrant women who visited emergency departments. However, the Nova Scotia Department of Health (NSDH) (2005) stresses the significance of having up-to-date information about any community in Nova Scotia in order to plan care in relation to the needs of that population. According to Statistics Canada (2011), the number of Arab women in Halifax was 2,480, and the Arab population is expected to grow; Arabic is the third most commonly spoken language in Halifax, after English and French (Statistics Canada, 2006).

Challenges that Arab Immigrant Women Face when Accessing and Utilizing the Health Care System in North America

Language barrier. Language and communication barriers were the most frequently reported challenges for Arab immigrant women when accessing the US HCS (Kulwicki, Miller, & Schim, 2000; Hattar-Pollara & Meleis, 1995). A qualitative study conducted by Kulwicki and colleagues (2000) explored the experiences, attitudes, and perceptions of Yemeni Arab immigrant women living in the United States (US) when accessing the US HCS; the 30 participants who did not speak English described how it was difficult to communicate or understand their health care providers, including their nurses and physicians, and how this challenge negatively affected their experiences and made them reluctant to access the health care system. In another study by Al-Shah, Ayash, Pharaon, and Gany (2008), 25 Arab immigrant women also living in the US were interviewed. They unanimously stated that even though they spoke English, they could not explain their symptoms and feelings accurately. Moreover, some Arab immigrant women in the same study mentioned that they brought their husbands, daughters, or sons to serve as interpreters. Meanwhile, these women felt uncomfortable to discuss their problems in front of their children or husbands (Al-Shah et al., 2008). Lack of interpreters and health materials in Arabic were also challenges that Arab immigrant women have faced (Al-Shah et al., 2008).

Recommendations were made by Aboul-Enein and Aboul-Enein (2010) for recruitment of more Arabic-speaking health care providers and more interpreters who fluently speak both Arabic and English in order to create a more welcoming, respectful environment, leading to a trustful therapeutic relationship between Arab immigrant women and health care providers. NSDH (2005) also emphasized the importance of hiring people from different cultures in the health sectors and the recruitment of more interpreters. However, the recruitment process of internationally educated health care providers in North America is time consuming and complex. Applicants need to go through numerous preparatory courses and exams to be eligible for licensure. In addition, clinical hours need to be fulfilled under Canadian or American supervision. This process needs to be modified or facilitated to achieve the goal of recruiting Arab health care providers while maintaining professional standards. Health education materials could also be translated into Arabic for patients who will understand these more clearly and easily than materials in English (Aboul-Enien & Aboul-Enein, 2010) and should be written in a simple, plain style (NSDH, 2005).

Cultural barrier. Cultural care is influenced by religion, politics, socio-economic status, world-views, environment, values and beliefs, history, language, gender, and other factors (Almutairi & Rondney, 2013; Leininger, 1996). Thus health care providers require knowledge of how these factors can be used to ensure the provision of culturally congruent care. When health care providers make decisions, care for, and interact with people in a way that is congruent with people's beliefs, values, health practices, and cultures, then the providers have the skills to provide culturally congruent care (AlMutair, Plummer, O'Brien, & Clerehan, 2014; Lackner, 2009). Kulwicki and colleagues (2000) found that incongruent cultural care led to frustration and disappointment for Arab immigrant women and health care providers, as well as limiting access to the US HCS. Incongruent cultural care results when health care providers, due to lack of knowledge, provide care that is not sensitive to the needs of patients who have different cultural backgrounds. That lack of knowledge also can influence health care providers' desire to care for Arab immigrant women (Marrone, 2008), which can lead to discriminatory behaviors (Kulwicki et al., 2000; Marrone, 2008). Further, the inadequate preparation of health care providers about the importance of cultural care can hinder members of the Arab community (including Arab immigrant women) from seeking medical advice and can limit their access to culturally congruent care (Kulwicki et al., 2000).

To enhance knowledge of other cultures, one of the Standards of Practice for registered nurses in the College of Registered Nurses of Nova Scotia (CRNNS) (2012) is knowledge-based practice and competence. This stresses the importance of cultural care and knowledge about other cultures among health care providers. Leininger (1997) and Yousef (2008) argued that a broader vision of nursing is achieved when we go beyond unicultural knowledge into multicultural care. Only with this thinking can health care providers move to a level where effective and congruent care is achievable. This cultural knowledge can then be translated into action through the skills and attitudes necessary to provide congruent care to clients from different cultures (Aboriginal Nurses Association of Canada [ABNAC], Canadian Association of Schools of Nursing [CASN], Canadian Nurses Association [CNA], 2009; NSDH, 2005).

Many theories and models explain cultural care, such as Leininger's Cultural Care Diversity and Universality theory; Campinha-Bacote's model, Giger and

Davidhizar Transcultural Model; Purnell Model of Cultural Competence; and Boyle and Andrews' Cultural Nursing Assessment Guide. Leininger's Cultural Care Diversity and Universality theory with the Sunrise model was one of the first theories that emphasized the similarities and differences among cultures and the importance of providing culturally unique care (Leininger & McFarland, 2006). This theory links cultures with care provided, and emphasizes the significance of providing unique individualized care that is congruent with a person's culture, along with standard universal care (Leininger, 1991). Providing care using this theory as a guide, nurses help patients to regain their health and well-being faster, to deal better with their disabilities, or to face death peacefully (Leininger, 1999). The Sunrise Model consists of three levels: the interaction between health care providers and individuals, families, and communities; the comprehension of the cultural and social structure; and peoples' world views.

Campinha-Bacote's is another model that stressed the significance of assessing each client individually to know the culture (ABNAC, CASN, CNA, 2009). In other words, it is a client-centered model of care. Campinha-Bacote (2002) developed this model to address the issue of disparities and inequities against minority groups in a society. The model provides a framework for health care providers that helps them to effectively provide culturally competent and congruent care. Cultural competent care refers to "the ability of the healthcare provider to bridge cultural gaps in caring, work with cultural differences, and enable clients … to achieve meaningful and supportive care. [It] requires specific knowledge, skills, and attitudes in the delivery of culturally congruent care" (Potter & Perry, 2006, p.120). Campinha-Bacote (2002) stressed in his model that cultural competence is a non-static process, in which health care providers should practice the five main constructs to provide culturally competent care: awareness, knowledge, skills, encounters, and a desire to satisfy the need of diverse groups.

Cultural awareness, however, is an “in-depth self-examination of one’s own background, recognizing biases, prejudices, and assumptions about other people” (Potter & Perry, 2006, p. 121). The second construct, cultural knowledge, commences when health care providers seek information and obtain a knowledge base about other cultures, and when they collect the information that helps them to make a culturally congruent physical assessment and act to provide culturally congruent care, they then move to the next step, which is cultural skills. Cultural encounter is the step in which health care providers interact directly and successfully with patients from other cultures. Cultural desire is “the motivation of the health care providers to *want* to, rather than *have* to, engage in the process of becoming culturally [competent]” (Campinha-Bacote, 2002, p. 182). “[It is] the genuine passion to be open and flexible with others, to accept differences and build on similarities, and to be willing to learn from others as cultural informants” (Campinha-Bacote, 2002, p.183).

Giger and Davidhizar Transcultural Model provides a systematic approach to help health care providers gain the skills required to provide culturally competent care. This model consists of six constructs: communication, space, time, social organization, environmental control, and biological variations (ABNAC, CASN, CNA, 2009; Bechtel, Davishizar, Rouge, & Mishawaka, 1999; Davidhizar & Giger, 1998; Giger & Davidhizar, 2002). Understanding verbal and nonverbal communication is integral in providing culturally competent care, and is considered one of the main ways to share a culture. Space refers to the distance preferred by individuals when interacting, and it has four constructs: proximity, body posture, attachment with the surrounding environment, and movement. Social organization is the way people in a specific culture organize themselves and the understanding of this organization is another means for providing culturally competent care. Further, health care providers should be aware of the group cultural perception of time and if a particular group are past, present, or future-oriented. Determining if persons believe in their ability to control the environment is another aspect of this cultural model and is important when caring for diverse patients. For example, those who believe in internal control and self-responsibility on one's own health may consider seeking medical advice as useless. Health care providers should also be aware of the biological variations of patients, as some diseases are linked to people from specific culture (Bechtel et al., 1999; Davidhizar & Giger, 1998; Giger & Davidhizar, 2002). For example, the Hispanic population has a higher incidence of diabetes, whereas African Americans have a higher incidence of cardiac diseases and cancer (Bechtel et al., 1999).

Purnell Model of Cultural Competence (2002) concerns the importance of knowledge and skills to understand people from other cultures and to provide culturally competent care. Its basic assumptions include health care providers' awareness that cultures are changing, that no one culture is superior to the other, that similarities and differences exist between and within cultures, and that patients' participation in their care improves their health outcomes. The model consists of primary and secondary characteristics and twelve domains that health care providers should be aware of when dealing with patients, as they determine the differences between individuals. Primary characteristics include nationality, age, gender, religion, and color; while the secondary ones include educational, socioeconomic, and marital status. The twelve domains are overview/heritage (e.g. country of origin, current residence, occupation), communication, family role and organization, workforce issues (e.g. gender role), high-risk behaviors (e.g. tobacco and alcohol use), bio-cultural ecology (e.g. skin color, genetic and hereditary diseases), nutrition, pregnancy and childbearing practices, death practices, spirituality, health care practice, and health care practitioners (e.g. gender of providers).

Andrews and Boyle's (1989) Cultural Nursing Assessment Guide consists of areas that should be addressed by nurses when assessing patients from other cultures, in order for nurses to provide culturally congruent and competent care. Nurses should assess patients' biological variation, communication styles, cultural restrictions, economics, educational background, health-related beliefs and practices, social networking, nutrition, value orientation, cultural affiliation, and religion and spirituality.

The aforementioned theories illustrate the importance of culturally congruent care provision for diverse populations and the complex ways in which culture is embodied in the lives of diverse populations, far beyond a simplistic understanding of beliefs and values (ABNAC, CASN, CNA, 2009; Campinha-Bacote, 2002). Thus an understanding of cultural awareness and the provision of culturally congruent care are the first steps in building a culturally safe environment by health care providers.

Cultural safety concerns the elimination of inequities that exist within health care systems, and is determined by clients receiving care (ABNAC, CASN, CNA, 2009). Gibbs (2005) defined cultural safety as the application of health care practices according to standard safety, while simultaneously meeting the specific cultural (health) practices of a patient. Cultural safety also addresses issues related to power imbalances and how such issues can jeopardize a patients' right to receiving culturally congruent care (Almutairi & Rondney, 2013). Improving clients' access to health care and understanding social and political contexts of health care are examples of providing culturally safe care that respects diversity within a health care system (ABNAC, CASN, CNA, 2009).

Continuous education through workshops and conferences that emphasize the importance of cultural care implementation can play an integral role in developing abilities and the cultural knowledge of health care providers (Campinha-Bacote, 2002; Yousef, 2008; NSDH, 2005). These educational sessions should include discussions related to various challenges to providing culturally safe care. Such challenges, include stereotyping, ignoring or fear from other cultures, and feeling superior over others (Borkan & Neher, 1991). These activities can motivate health care providers to gain more educational knowledge and training to improve their ability to provide culturally safe care (Campinha-Bacote, 2002; Leininger, 1991). Only through an educational awareness, knowledge and desire for change, will health care providers acquire the skills to perform culturally safe care, including assessments of culturally diverse patients (Campinha-Bacote, 2002).

Al-Shahri (2002) stressed that increasing health care providers' awareness and knowledge with regard to cultural care not only enhances their competence in the area, but also their confidence when dealing with Saudi patients who are Arabs, making their experience enjoyable rather than challenging. Cultural awareness also minimizes cultural shock and misinterpretation and/or discriminatory judgments that could be based on outsiders with different cultural backgrounds.

Yousef (2008) contended that nurses should know the factors that shape Arab culture which leads to an in-depth understanding of this culture. O'Mahony and Donnelly (2010) underscored the perspectives that immigrant women are shaped by their past lives in their home countries. It is therefore important for providers to consider the importance of history and other contextual factors of immigrant women—such as culture, social, economic, and political factors—when understanding their current daily lives.

Discrimination and stereotype challenges. In addition to communication and incongruent care challenges, stereotyping and discrimination were also problems (Hattar-Pollara & Meleis, 1995) that led to Arab immigrant women's withdrawal from accessing the US HCS (Marrone, 2008). Although there is difficulty distinguishing stereotyping from discrimination, Stewart, Schiavo, Herzog, and Franko (2008) defined stereotyping as the knowledge or belief that is held by a person about other individuals, whereas discrimination is the negative action that *results* from the stereotyping. Stereotyping is thus the generalized belief that is held and leads to certain attitudes against a group and simplifies their diversity into a fixed homogenous culture (Kanahara, 2006). Discrimination occurs when nurses and/or other health care providers treat patients differently and unfairly based on their “race, religion, gender, social class, lifestyle behaviors, nationality, physical disability, and political beliefs” (Steck, 2012, p. 101).

Public media has a significant influence on American and Canadian societies’ attitudes toward Arabs. Generally, what is presented on television, radio, and cinema links Arabs with terrorism and criminals, which in turn leads to negative reactions toward them, such as discrimination and stereotyping (Marrone, 2008). Hamdan (2009a) underscored that “[i]n the Western hegemonic discourses, not only was Muslim women’s status used to target Islam, but these discourses also used other images of Arabs and Muslims that commonly characterized them as anti-Western, uncivilized, backward, uneducated, illiterate, violent, and rife with men who subordinate women” (p. 2).

Islamic faith can also be a reason for some health care providers to stereotype or discriminate against the entire group of Arabs. Some women stated that their questions were not being answered by health care providers, and they interpreted this behavior as discriminatory (Kulwicki et al., 2000). According to Al- Shah and colleagues (2008), some Arab immigrant women reported that wearing head covers could also be a source of discrimination; some health care providers ignored their needs while others assumed (stereotyped) that they did not speak English or were being abused by their husbands (Al-Shah et al., 2008).

These behaviors should not be acceptable in the health field, according to the Canadian Nursing Association (CNA) code of ethics (2008) and the Canadian Medical Association (CMA) code of ethics (2004), which emphasize the respect, dignity, and uniqueness of clients. The American Nursing Association (ANA) code of ethics also stresses the importance of treating clients with respect regardless of their race, culture, gender, or sexual orientation (Seifert, 2008). Moreover, the respect for clients' diversity, which includes their cultural beliefs and values, is a cornerstone in the registered nurses' standards of practice (CRNNS, 2012).

Health care accessibility challenges. While immigrant women encounter many challenges when navigating the Canadian health care system, the complexity of the health care system, along with the lack of a clear strategy of how to access it, were all difficulties identified by women. Most Arab immigrants in the US in a study by Kulwicki and colleagues (2000) found the process of accessing the health care system in the U.S. nebulous and difficult. This uncomfortable feeling stemmed from the differences between the US HCS and what Arabs were used to in their home countries. Another reason was the lack of awareness about how, where, and when to contact health care providers. In other words, no clear, simple system was available on hand for people other than Americans. Other challenges that Arab immigrant women encountered when accessing the US HCS were the long waiting time and the difficulty of finding a place for their children during their hospital visits (Al-Shah et al., 2008).

Challenges related to modesty. Modesty and chastity are highly valued virtues in Arab cultures. Many Arab women cover their heads with what is called *hijab*, and some choose to cover their entire face or to wear veils. Most wear long-sleeved shirts and clothes that do not cling to their bodies' shape. An example that shows their modesty is that the exposure of women's bodies to a male health provider is not a preferable behavior (Gulam, 2003). However, the possibility of having women health care providers can be difficult in ambulatory or walk-in clinics (Kulwicki et al., 2000). On the other hand, some Arab women may allow male providers to examine them, especially in emergencies, with the presence of a relative (Al-Shahri, 2002). Most Arab immigrant women feel uncomfortable and extremely stressed when discussing sensitive issues with a male provider (Aboul-Enein & Aboul-Enein, 2010; Yousef, 2008); some Arab immigrant women consider questions about sexual activities outside of marriage to be disrespectful and insulting, even if they are not married. They can also do not prefer gender-mixed waiting areas or wards. Given the Islamic faith of Muslim Arab immigrant women, finding a quiet and clean place to perform their prayers in time can be a very real source of stress and anxiety (Al-Shahri, 2002).

Challenges involving gender differences. As identified in the literature, the backgrounds that Arab immigrant women have related to gender and power differences are a major problem when accessing the US HCS. A culturally acceptable trend in Arabic countries is the absolute power that men have over women, which contributes to Arab women's dependency (Aboul-Enein & Aboul-Enein, 2010). Arab women are expected to conform to the dominant culture in their countries and they would potentially feel ashamed if they did not (Hattar-Pollara & Meleis, 1995). Consequently, Arab women carry these behaviors with them when moving to North America. When accessing health care, Arab immigrant women do not feel independent in their ability to lead their own treatment decisions and lack confidence in their independent decision-making (Al-Shahri, 2002, McKinnes, 1999). Thus Al-

Shahri, (2002) indicated that Arab immigrant women often prefer to authorize a male relative to sign medical consent forms, though the woman has the right to make her own decision. For example, an Arab immigrant woman may allow her male relative to sign the consent when she needs a surgery, although she has the physical and mental capabilities to sign it herself.

Arab immigrant women encountered many challenges when accessing the US HCS. These challenges could be faced by Arab immigrant women in similar ways when accessing the Canadian health care system. To date, no published studies conducted concern the experiences of Arab immigrant women in any health care settings in Canada, including EDs. The experiences in EDs differ substantially from those of clinic visits, such as walk-in-clinics or out-patient diagnostic tests; the urgency of the patients' situations and the severity of the diseases may add more challenges to the experience, especially when it is a first-time visit. Hence, a study about the first experiences of Arab immigrant women when visiting EDs in HRM was warranted.

Chapter Two

Methodology and Methods

A feminist phenomenology is necessary to understand women's orientation(s) to the world. How each woman understands herself in the world and how she is understood by others depends upon a woman's embodied experiences within a variety of social contexts and the value society places on her embodied existence. (Goldberg, Ryan, & Sawchyn, 2009, p.541)

Methodology

The methodology used to guide the analysis and interpretation of this research was feminist phenomenology. Insofar as this study examined gendered experiences of Arab immigrant women in EDs in HRM, feminist phenomenology, an integration of phenomenological and feminist methodologies, aligned well with the topic of interest.

Phenomenology

Phenomenology as a methodological tradition focuses on the deep comprehension of meaning and the uniqueness of human beings as they interact with their environment (Lopez & Willis, 2004). This approach to research also studies the context of people's lives. That is to say, lives cannot be separated from their social, cultural, and political contexts (Draucker, 1999). Phenomenology "allow[s], and indeed encourage[s], the complexity and depth of human experience to be expressed" (Mackey, 2005, p. 9). It includes both description and interpretation of the phenomenon (Goldberg, 2004).

Descriptive and interpretive phenomenology. Historically, phenomenology originated as an alternative form of knowledge to the dualism posited by Descartes after the First World War. Originating in the discipline of philosophy with the work of Husserl (Groenewald, 2004), the initial paradigm argued for the separation of prior knowledge when undertaking an inquiry. Moreover, continuous self-assessment was necessary to determine researcher bias in this descriptive phenomenological tradition. Husserl's view further argued that "…reality [was] considered objective and independent of history and context" (Lopez & Willis, 2004, p. 728). In other words, Husserl argued for a type of bracketing of experience, often referred to as phenomenological reductionism (Laverty, 2003).

Unlike Husserl, his student, Heidegger, who further developed his ideas (Lopez & Wills, 2004), articulated the importance of context, situatedness, environment, and the concept of being-in-the-world (*Dasein*) (van Manen, 1997). These became essential to the phenomenological project, according to Heidegger, and further moved the tradition from the descriptive to the interpretive stream (Walters, 1995). It is within the interpretive stream, underpinned by existential phenomenology, that this research is aligned, as this inquiry examined the storied and gendered experiences of Arab immigrant women interpreted within an embodied framework in the context of health care services through EDs in HRM.

Existential phenomenology. While Husserl (1964/2010) and Heidegger (1962/2005) are best associated with the descriptive and interpretive traditions of phenomenology, the existential movement further extends the historical tradition and is often aligned with such philosophers as Sartre (1948/1973) and Merleau-Ponty

(1958/2005). Sartre’s (1948/1973) existentialism articulated a concept of freedom that was both situated and non-absolute (Jones, 1998; 2001). On such a view, human beings are free to choose but they are responsible for their choices and the meanings of their lives cannot be separated from the world surrounding them. While this notion of freedom is an important underpinning of the existential tradition, it is the concept of embodiment and intersubjectivity found in the writings of Merleau-Ponty (1958/2005) that are relevant to this inquiry and form the framework to carry out this research.

“The nurse researcher who works within the Merleau-Ponty tradition seeks to discover [study] participants’/patients’ perception of their lived experience” (Thomas, 2005, p.69). Merleau-Ponty’s writings are relevant to the research because Arab immigrant women who are living in Canada embody a place and space other than their own; they access a health care system that is different from what they were used to. This further disrupts and disturbs their taken-for-granted embodied experiences. Hamdan (2009a), a feminist and Arabic scholar, argued that moving from one place into another entails discontinuity and disruption in ones “thoughts, dreams, homes, and careers” (p. 30). Therefore, understanding Arab immigrant women’s experiences is crucial to optimizing their health and wellness, especially when accessing the Canadian health care system.

The notion of embodiment as central to the writings of Merleau-Ponty (1958/2005) provided an understanding of the relation of the body as lived. This notion of the lived body resulted in a conceptualization of the body that engages with the world—its smells, sounds, movements, and senses with others being situated in the world and with the surrounding environment. This further accounted for a socio-cultural-political relationality of the body to the environment. Merleau-Ponty indicated that persons interact with their surrounding world through an interconnectedness of the mind-body relationship—one cannot be separated, compartmentalized, and therefore jettisoned from the other. (Goldberg, 2002; 2004; 2005; Merleau-Ponty, 1958/2005). This inherent mind-body relationship is further extended through the notion intersubjectivity. “Intersubjectivity, although not a theory or set of theories, refers to the ways in which subjects are ensconced in the world together, how one is both effected by and effects the self and others in relations” (Goldberg, 2008, p. 81). It encapsulates a type of interactive relationship that offers co-existence with others and the life-world (Merleau-Ponty, 1958/2005; Ryan, Goldberg, & Evans, 2010; Sartre, 1948/1973).

In this research, the interaction between Arab immigrant women and health care providers, and/or staff in the ED, was examined to illuminate a deeper understanding of Arab immigrant women's gendered experiences. A relationality was mutually created through interactions between me (the researcher) and the participants to interpret and unravel hidden meanings of the narration (Koch, 1995) based on their diverse realities and embodied experiences. The use of Merleau-Ponty’s (1958/2005) existential phenomenology was used to align the research in understandings of embodiment and intersubjectivity and therefore provided a substantive, methodological and pragmatic framework to both ground the research and mutually engage in embodied work with study participants on this interpretive journey.

Although the notion of embodiment was originally developed in application to the Western World, it aligns well with Arab immigrant women's cultural experiences. For example, often within Arab culture, women prefer not to interact with health care providers who are men. Arab women's embodied experiences—how they inhabit their situatedness within their bodily experience is not well aligned with western men—including health care providers. Thus there was often a disruption, disturbance, and bodily dislocatedness of experience when encountering health care providers who were men in EDs. Therefore, understanding how Arab immigrant women live their bodies (embodiment) in health care contexts has significant relevance and aligns well within the context of the research study.

While the work of Merleau-Ponty (1958/2005) was well aligned with this research inquiry, his scholarship has nevertheless been critiqued for providing a perspective grounded in male bias (Grosz, 1994). Therefore, integrating a feminist perspective to further understand gendered experiences of Arab immigrant women as they accessed EDs was warranted.

Feminist Theory

Feminist theory in tandem with phenomenology guided the interpretation and analysis of this research study. Feminist theory emerged in response to the situation of the subjugation and oppression of women (Kincheloe & McLaren, 2005). Feminist theory takes seriously issues of power as related to gender (Mackey, 2005) and how a marginalized population of women can be empowered to act in order to remove hegemonic and/or oppressive constraints placed on them (Creswell, 2007; Kincheloe & McLaren, 2005). According to Routledge (2007), feminism values women's experiences in their daily living and explores possible actions to help women achieve equal rights in societies. One of the inherited hegemonies is the privileging of men, specifically in research (Routledge, 2007), and the marginalization of women in research generally (Perry, 1994). As a result, feminists argue that there is a need to change the trends of male prevalence and to focus more on women in research (Aranda, 2005; Routledge, 2007; Seibold, 2000). This gender domination and the fact that some Arab immigrant women came from countries where they were following the decisions of men without question, has fostered my interest in a feminist phenomenological perspective and particularly in understanding the oppressions and the hegemonies that marginalize Arab immigrant women when accessing the Canadian health care system, as well as how we can work collaboratively to remove such oppression. In so doing, the integration of a feminist methodology with an existential phenomenology extends the knowledge of a gendered perspective to the experiences of Arabic immigrant women.

In feminist studies, researchers critique the experiences of women as well as any kinds of oppression they face (Routledge, 2007) and emphasize that they have the right to have their voices heard and their needs met (Creswell, 2007; Kincheloe & McLaren, 2005). This critique tends to identify the sources of hegemony and to work in collaboration with the oppressed population to find creative ways that could improve their situation (Forbe et al., 1999). Hall and Stevens (1991), and Seibold (2000) argued that feminist theories have three main principles: the placement of high value on women's needs, the unraveling of the causes of women's oppression, and the obligation to take actions that lead to social change. In addition, Seibold (2000) emphasized that the knowledge produced from feminist research must help both the participants and the researchers, and that there should be interactions between them in order to explicitly express their feelings. Further, studies that focus on women provide a unique perspective and could be an alternative to patriarchal social beliefs (Routledge, 2007). Wuest (1994) emphasized that feminism is about the "elimination of limitations and the attainment of equal rights… [, along with valuing] the unique qualities and abilities that women had to offer society" (p. 86). Knowledge garnered from the study elucidates how health care may unintentionally disadvantage some individuals and groups of women, particularly those who are Arab speaking in accessing emergency health care in HRM.

Although the aspects of embodiment intersubjectivity and taken-for-granted experiences in Merleau-Ponty's concept of existential phenomenology are also at the center of a feminist perspective, Merleau-Ponty provided a framework that focused on men's perspectives (Goldberg, 2004; Ryan et al., 2010), not on women and/or disenfranchised groups. Thus the combination of feminism and existential phenomenology provided a framework that extends the scope of the research to involve issues of power and equity. This furthers a critique of women's experiences within patriarchal societies, thus moving it beyond the level of the individual within the health care system and accounting for experiences that are socially, culturally, economically, historically, and politically situated (Goldberg, 2005; Goldberg, Ryan, & Sawchyn, 2009; Goldberg, Harbin, & Campbell, 2011; Ryan et al., 2010).

Feminist Theory, Islamic Feminism, and Arab Culture

For over a century, Muslim women have argued for their rights and for gender equity and power (Hamdan, 2009a); pure Islam supports women's rights and protects women from various forms of oppression (Amjad, 2011; Haideh, 2011). It also affirms the complementary roles between men and women (Amjad, 2011). Amjad (2011) and Haideh (2011) used the term *Islamic feminism* to refer to the use of feminism in Islamic societies, and indicated that women's freedom is constructed within the pure Islamic framework and guidelines. Haideh (2011) also emphasized that this is the freedom to which most Muslim women align themselves and ultimately wish to practice. This differs from the cultural practices that are often imposed on Muslim women—those that have little to do with faith, as they have been historically and culturally constructed. Given this understanding, Islam appears congruent with many Western notions of feminism.

Muslim women, however, live in patriarchal societies, where men want to have power and authority over women, often forcing women to follow culturally imposed norms with little to no opportunity to critique the status quo. As such, there is a rigid interpretation of the Holy Qur’an and Prophet's Sunnah that has further contributed to the absolute authority of men over women (Haideh, 2011; Hamdan, 2009a).

Various western scholars have argued that there is a tension between Western feminism and Islamic views of feminism, insofar as feminism broadly calls for liberation and women's freedom, which clashes with Islam (Hamdan, 2009a; Vidyasagar & Rea, 2004). In other words, some Islamic rules may be interpreted as privileging men over women. However, Western feminist scholars who adopt this tension confuse cultural practices within Islamic regulations. Therefore, Arab women are viewed as victims as a result of their Islam religion (Crabtree, 2011; Hamdan, 2009a). Such scholars overlook the diversity and complexity within any given culture.

When Arab women consider themselves an oppressed and/or disenfranchised group and advocate freedom from patriarchy as the dominant discourse, their perspective aligns well with the Western notion of feminism. This entails a re-examination of the current Islamic practices to understand their cultural basis is not found in Islamic faith, thus justifying an Islamic reform (Haideh, 2011; Ramadan, 2004). Hamdan (2009a) claimed that this reform is important when cultural practices do not have an Islamic root.

However, some Arab women are accustomed to following the norm of men's power in their societies and don't consider themselves an oppressed group. As a researcher, in this situation, I am working collaboratively with the women to make changes as they deem necessary—improving only what they see useful in the context of their health care decisions and circumstances. Feminism in this situation is defined as the freedom of choice from the perspective of the women. However, women's choices are not absolute and are influenced by social, political, historical and cultural contexts. Thus, understanding the context of women's decision-making and influence on their choice is imperative.

Method

Collecting the Data

Interviews. Interviewing is often considered the main method for data collection in phenomenological research because it gives an opportunity to the participants to describe their experiences and for their voices to be heard (Salmon, 1999). In the context of the research, the interviews conducted were conversational, dialogical, and engaging with open-ended questions (Goldberg, 2005; Patton, 2002b; Ryan et al., 2010). After getting approval from Dalhousie Research Ethics Board, six Arab immigrant women participants were recruited from the community (justification is given for the sample size in the next section). One semi-structured interview was conducted with each participant, in keeping with the tenets of phenomenological research, as it is the most suitable method for data collection in phenomenological research (Balls, 2009). Interviews lasted for 60 to 90 minutes. The interviews were often held in places of familiarity, allowing participants to feel comfortable (Balls, 2009). Participants selected a date, time, and a place for the interview to take place. Mackey (2005) emphasized that researchers who adopt a phenomenological methodology examine participants in their natural settings, which assists in getting a deeper understanding of the phenomena under study. One interview was held at a participant's home, two in their apartments' lobby, one at a participant's work offices, and two in Dalhousie classrooms. I started the interviews with personal conversation and by asking them about their feelings as they live away from home. Further, self-disclosure was a technique used before starting the interviews in order for them to feel trust and share their personal experiences. Five interviews were audio-taped after an informed consent was signed by the participants, whereas one interview was handwritten, as requested by the participant. The hand written manuscript was then handed in to this participant to ensure the accuracy of the written material. The language of these interviews along with the consent forms were in both Arabic and English. However, participants preferred to have the interviews done in Arabic, as they felt their stories and experiences were conveyed more accurately in their native language. The interviews were then translated into English and transcribed verbatim by a certified translator, including non-verbal cues, such as silence and/or laughter. The translations, along with the audio-tapes, were then double checked for the accuracy of the meaning by me, the researcher.

During the interviews, the participants were asked to describe their experiences when they previously visited any ED in HRM for the first time, including what they found supportive and/or challenging (see: Appendix A- interview questions guide for more details). Demographic data was also collected (see: Appendix B- Screening Questionnaires and Appendix C- Participants Demographic Data). After the interviews, a copy of the translated text was offered to each participant (if they wanted a copy), and they were given the opportunity to ask questions and/or clarify what was written. This gave them an opportunity to review the texts before the focus group (group interview: discussed below), in order to make sure that what was written was what they wanted to share and to give them a chance to elaborate further on what they had said; they checked the texts for both accuracy and preparation for the focus group (a group interview) interviews (Byrne, 2001; Patton, 2002b). After each interview, the participant was asked if she would be interested in participating in a focus group. Only three of participants were interested in reading the texts and in participating in the focus group. The translated texts were given to participants immediately after I received it from the translator at the places selected by them: two at Dalhousie classrooms and one at the participant's office.

Focus group (group interview). Focus groups (group interviews) are “group interviews on a specific topic that seek to generate qualitative data by capitalizing on group interaction” (Bench, Day, & Griffiths, 2011, p. 444). Jones, Sambrook, and Irevine (2009) suggest that a focus group (group interview) is a compatible method for data collection in a phenomenological approach. Moreover, a focus group is beneficial because it allows an open discussion that may raise new and shared issues, which in turn may help to deepen the knowledge about a specific phenomenon. As a result, a focus group was held with three participants who were previously interviewed individually and who expressed an interest in participating in the focus group, with the researcher’s intent of gaining a deeper understanding of experiences of Arab immigrant women in EDs in HRM.

The group interview was held in a group meeting room at Dalhousie University, which is a central location convenient for participants at a mutually convenient date and time. Focus group questions were based on participants' narratives derived from preliminary analysis from their initial interview data. The session was audio-taped, and notes were taken about participants' non-verbal communication and interactions in order to analyze the experience. Data obtained from the focus group further informed the analysis process.

Having these women gathered in a focus group after the individual interviews helped them to co-create ideas for some of their problems; co-creation in this context refers to the sharing of ideas that involves patients as an integral part in the improvement process (Kaminski, 2009). The focus group experience also enabled them to support each other emotionally and to educate each other regarding available resources; each woman was relieved as they felt that someone else had shared a similar experience, and they benefited from hearing what others did and/or which services others used to solve similar problems. They also built on some of what they had shared in the individual interviews. The individual interviews enabled them to tell stories that they considered confidential and did not want to share with other women in the focus group.

Reflective journaling. Following each interview and the focus group, I kept a reflective journal, in which I included my thoughts, challenges in the interview, environment observations, feelings, and views of the contexts. This free writing technique improved subsequent interviews and made me, as the researcher, more oriented to what went well and/or what needed more effort or change. The reflective journal also assisted in maintaining me, the researcher, as a key instrument in the study. My perspective and my experience thus was immersed in and reflected upon as part of the research process.

Sample

The study population. The study population consisted of Arab immigrant women who visited EDs in HRM for the first time. Purposeful sampling selecting participants with different backgrounds was used by selecting heterogeneous cases that could address and describe the issues in the study: participants were Arab immigrant women of different ages, of any religious orientation, who were Arabic monolingual or who spoke another language besides Arabic, in order to explore the issues extensively and to learn if and how these differences affected their experiences.

The sampling strategies. Purposeful sampling selecting participants with different backgrounds was used in this research. According to Patton (2002a), "the logic and power of purposeful sampling lie in selecting information-rich cases for study in depth" (p. 230) that enhance understanding of the issue being studied. However, finding a sufficiently diverse population pool was not fully feasible. As such, a combination of snowball and criterion sampling were used (Patton, 2002a): approximately six weeks after the recruitment process commenced, snowball and criterion sampling were initiated to assist with the sampling process. With the aforementioned sampling techniques, each participant was asked if she knew another Arab immigrant woman meeting inclusion criteria not found in the other participants, in order to provide the desired diversity for the anticipated sample. This process assisted in finding information-rich cases.

The sample size. In qualitative research, there is no standard rule for sample size. Sample size depends on the information researchers seek to know, the purpose of the study, what contributes to research credibility, and the availability of resources and time. However, a small sample size is useful for getting in-depth information (Patton, 2002a). As a result, I started with a reasonable sample size required to enrich my study and address all the dimensions under study, which entailed six participants—also meeting feasibility requirements related to availability of the Arab immigrant women population for recruitment in HRM.

Inclusion criteria.

1) Arab immigrant women were included if their ages were between 19 and 50, because I wanted to explore experiences of Arab immigrant women who were adults. The elderly and children may have different needs, which could be addressed in a different study. Selecting this age variation, I was able to address challenges faced by women of variable ages who had visited EDs in HRM. Other inclusion criteria were as follows:

2) Arab immigrant women who visited EDs in HRM within the past two years, thus allowing for the feasibility of obtaining the anticipated sample size. (The possibility of forgetting some of their experiences was likely not significant since visiting a hospital for the first time in another country would be a memorable experience, particularly if one were ill and English was not one's first language);

3) Arab immigrant women who spoke Arabic as their first language;

4) Arab immigrant women who had any religious orientation because, despite different religions, Arabic countries share almost the same cultural backgrounds and have the same language. For example, many Arab women wear a head cover and take the lead inside the house in raising and teaching their children regardless of their religions;

5) Arab immigrant women who visited EDs in HRM for the first time because the first visit is the most challenging: women may not have any idea about the registration process and the directions, in addition to other potential challenges they may encounter from not speaking English as their first language;

6) Arab immigrant women who had the mental and physical capacity to sign informed consent.

Although Arab immigrant women share the same culture, there are diversities in some practices that cannot be overlooked. For example, some Arab immigrant women are Muslim while others are Christian; some wear head covers whereas others cover their faces or wear veils. Another example is that some Arab immigrant women prefer health care providers who are men to attend a physical examination of Arab immigrant women, while others do not prefer this practice, and at times may forbid it, even in emergency situations.

Exclusion criteria.

1) Arab immigrant women were excluded from the study if they were born and/or raised in a country other than Arabic, or spoke a language other than Arabic as their first language. The purpose of the research was to explore experiences of Arab immigrant women in Canada; being from a non-Arabic country may affect a person's culture, needs, and experiences. For this reason, immigrant women from any Arabic country could potentially participate in the study. Those from non-Arabic countries were excluded. Arabic countries included in the study are Saudi Arabia, Lebanon, Qatar, Bahrain, Kuwait, Syria, Iraq, United Arab Emirates, Jordan, Yemen, Egypt, Sudan, Morocco, Algeria, Palestine, and Tunisia;

2) Language plays an important role in communication. Having difficulties understanding or communicating with others affects experiences. For these reasons, only those participants who spoke the Arabic language, which is the native language in the Arabic countries listed above, were included in the study.

Participant recruitment strategies. Participants were recruited in the following ways:

1) A brief presentation of the purpose of the study and the need for participants was arranged with the leader of the Islamic Association of Nova Scotia, in order to give Arabic immigrant women the chance to ask questions about the study (see: Appendix D- Letter From The Leader of Islamic Association of Nova Scotia).
2) Posters (see: Appendix E- Recruitment Advertisement [Text-Based]) were disseminated in mosques, community centers, and interpreter centers.
3) Social networking was another means of recruitment, through a brief description of the study on Facebook and Arabic forums.

The poster and the social networking communication had the researcher's contact information. When a potential participant was interested and called the researcher regarding recruitment, demographic questions were asked to determine eligibility (see: Appendix B- Screening Questionnaires). If eligible, a time, date, and location were scheduled to explain the consent. Otherwise, an explanation was made that the demographic data would be destroyed immediately following the phone call or the email (see: Appendices E and F- Telephone Script and Email Script for more details). If a time, date, and location were confirmed with an eligible participant, the study was explained, including risks and possible benefits, before the interview took place. If still interested, the consent was signed by the participant while emphasizing that her participation was voluntary.

As the strategy was purposeful sampling, it was important to be selective in determining who could enrich the results. The screening questions helped in recruiting participants who were eligible and assisted the principal researcher to be selective so that participants reflected the diversity of Arab immigrant women. Detailed justification of the use of demographic questions is given in Appendix B.

Six participants were recruited: four from Saudi Arabia, one from Yemen, and one from United Arab Emirates. All were highly educated and middle to upper class in their native societies and in Canada. Meriam was a registered nurse in Canada and in her home country. In her home country, she was a lecturer at a university, teaching nursing to undergraduate students. Rogaiah had a strong personality and was a known voice in her community and she was an active person involved in various activities in the community; she held a class in her house where she taught Arab children the Holy Qur’an and the Prophet's Sunnah. She also communicated with people who hold political positions in her home country. The other four were students: Safa, Nada, and Iman were Masters students at Dalhousie University studying mathematics and physics, while Doaa was studying English as a second language at the Dalhousie University language center at the time of the study.

Setting. Participants for the study were recruited from HRM. There are 2480 Arabic immigrant women living in Halifax (Statistics Canada, 2011), which supports both the need for the research and potential success of the study being carried out in HRM. EDs consist of nurses, physicians, paramedics, and other health care providers who collaborate to provide efficient care. Clients go through triaging and, before seeing their physicians, wait in a gender-mixed area in the ED’s main lobby.

Timeline

The duration for the study was 15 months. Data collection, interviews and the focus group, took seven months. After data collection, data analysis and writing took eight months. In phenomenological research, data analysis commences with the onset of the data collection process. Thus I started to analyze the data after the first interview and the analysis continued until I satisfied that no more themes could be found.

Thematic Data Analysis

Thematic analysis in phenomenology means examining and interpreting participants' experiences and stories, capturing similar ideas, and clustering them into themes (DeSantis & Ugarriza, 2000). “A theme is an abstract entity that brings meaning and identity to a recurrent experience and its variant manifestations. As such, a theme captures and unifies the nature or basis of the experience into a meaningful whole” (DeSantis & Ugarriza, 2000, p. 362). The resulting themes were based on the perspective of the researchers (Keddy, Gregor, Foster & Denney, 1999) and the focus of the study. Interpretation started as the interviews were conducted (van Manen, 1997).

As recommended by Braun and Clarke (2006) and van Manen (1997), I kept revisiting and reviewing the themes until I was confident that no more themes could be found. Goldberg (2005) also emphasized that reading, writing, and rewriting help in developing the phenomenological text through their reflection of the embodied meaning of the data. A unique, articulated definition was then given to each theme, and a phenomenological text was written. A phenomenological text should stimulate a reader's thinking and touch their senses in the broadest and deepest aspect of their experiences (van Manen, 1997).

Recommendations from committee members and study participants in combination with interpretations of my reflective journals were helpful in completing the analysis process. Taking into consideration the existentials of time, body, space, and relationship (van Manen, 1997), thematizing informed the analysis process by looking at meanings within the participants' experiences in EDs, along with the impact of oppression and power differences in their embodied and intersubjective experiences, as well as language, and non-verbal communication.

Ethical Consideration

The proposal was submitted to the Dalhousie Research Ethics Board. After I obtained the ethics approval, recruitment started, using the strategies mentioned above. When an Arab immigrant woman agreed to participate in the study, oral consent (see Appendices F and G Telephone and Email Script) was asked for the purpose of collecting demographic data (see: Appendix B- Screening Questionnaires) from women who called or sent an email to participate after the ads were posted or distributed. I explained that these demographic questions would be used to determine their eligibility and that the data would be destroyed after the call when a woman was not eligible. No compensation was given to participants, and they were asked to select a time, date, and location convenient for them in order to prevent them from paying any charge for parking or transportation when meeting for the interviews and the focus group (the group interview).

Before the interview started, I explained the purpose of the study again, the possible benefits, the risks, and the time of commitment. I went through the written informed consent with participants, and asked them to sign if still interested. (see: Appendix H- Interview Consent Form). There was no physical harm associated with this study. However, participants may have felt uncomfortable when discussing sensitive topics and/or personal experiences, such as the stereotyping or discrimination that they may have encountered when accessing EDs in HRM. They were not required to answer any questions, particularly ones that could potentially cause distress. Also, there was no direct benefit associated with participating in this study. Participants may have felt comfortable when sharing their experiences with other participants in the focus group (the group interview) who have shared similar experiences; these possible benefits, however, were not discussed with participants because this was not the main aim of this study.

I also stressed that participation was voluntary and that participants could leave the study at any point or refuse to answer any question. The information that was collected before the withdrawal time would be used in the study, unless a participant indicated that none of the data was to be used in the study. After the explanation was completed, I asked each participant if she understood and/or needed further explanation. If a participant lacked the capacity to provide informed consent, she would not be eligible to participate. For example, if a women was interested in participating but did not have the mental capacity to sign the consent, such as having significant learning disabilities (Dimond, 2005). The participants' general mental and physical capacities were determined after the initial conversation and while explaining the consent.

Participants were asked to sign a written consent form before the interview. After the interview, they were asked if they would be interested in participating in a focus group (a group interview). If interested, the aforementioned points about the benefits and risks were reviewed again in appropriate detail prior to the initiation of the focus group. Participants were then asked to sign another written consent form related to the focus group (see: Appendix I- Group Interview Consent Form). Both the individual and the group interview consent were co-signed by me as a principal researcher. A copy of the consent, which was either in English or Arabic, was given to each participant.

All the data was and will be kept confidential. The audiotapes were kept in a locked cabinet, when not in use, in my home office and destroyed after they were transcribed. The signed consent forms were kept in separate locked storage. The laptop that was used for analysis was also kept in a locked cabinet and was password protected. The laptop, the transcripts, and the audiotapes were kept in my home office and the door was locked when data were not in use. I am the person who is responsible for keeping the data confidential. Members of the research team could have access to the data for the purposes of analysis. The data will be destroyed five years after the completion of the study. The Arabic audiotapes were given to a translator in order to translate them into English. All the audiotapes were given to a transcriptionist. The transcriptionist and the translator were asked to sign confidentiality forms before the tapes were given to them, and a clear statement was written in the consent forms to ensure confidentiality and to ensure that participants are aware of the risk of breaching confidentiality (see: Appendix J– Confidentiality Agreement Form).

Breach of confidentiality was a risk associated with participating in the study. A clear explanation was given to participants in the focus group (the group interview) that all the information should be kept confidential and not be shared with any other person, and they were asked to sign that they understood this information. However, the risk for the breach was clearly stated in the focus group consent form, particularly as the Arab community is small, and there was the risk that participants knew each other outside of the research experience. Thus confidentiality could not be guaranteed.

Some of the data was sensitive because the participants were asked about their experiences when visiting EDs in HRM. This included, for example, personally sensitive stories. This was not the purpose of the study, and pseudonyms were used to protect a participant's identity and to minimize the risk for breach of confidentiality. I made clear to the women who participated in the study the following: If disclosure of any form of abuse or neglect occurred in the context of the interview, I would have a duty to report this to the relevant protective services. For example, if a woman indicated that she was hit physically by a nurse or asked to leave the ED with no treatment provided, I would report this staff person to the regulatory body. However, if a woman disclosed the need for protection, my role was not to provide counseling but to provide the relevant contact information for follow-up services (i.e. social worker).

Pseudonyms were used whenever a direct quotation and/or experience was included in the study, and the transcriptionist was asked to hide the identity of all participants. No individual health care provider was identified; the person's job title, such as a nurse or a doctor, was used instead. This ensured confidentiality and prevented any participant from being directly identified. Pseudonyms were used throughout the research process starting from transcription and ending with data analysis and the final written text. Participants were not given a chance to see their directly quoted material until the final text was written.

This directly quoted material was used in the final report to support emerging themes. However, no names or any information that could identify a participant were used. Before signing the interview and the group interview consents, I explained to participants that quotations would be used. I also confirmed this after the interviews and emphasized that no names or information that could identify them would be used. The quoted material did not have any information that revealed the identity of any participant or any health care provider.

At the end of the study, the data was placed in storage at Dalhousie University in the School of Nursing, in a secured place used for the purpose of keeping research data for five years; the data will be shredded after that and placed in confidential shredding bins. Team members may use this information in another research study after getting the required approval. The overall results were discussed with participants who requested this in the consent. A copy of any related published articles will also be given to interested participants. However, individual results were not and will not be provided to study participants.

The Significance of the Study

The proposed study examined gendered experiences of Arab immigrant women when accessing the Canadian health care system through EDs in HRM. By way of a feminist phenomenological framework, the research offers a deeper understanding of this population of often marginalized women— including their health care beliefs, values, and attitudes—while engaging with health care providers. Bringing Arab immigrant women's experiences to the attention of health care providers may assist health care providers in providing safe, ethical, competent, and equitable care. The research also provides a basis for future studies concerning Arab immigrant women, which in tandem with the broader body of evidence related to immigrant women and emergency services, may contribute to institutional policy development, best practice guidelines, educational curricula, and continuing education for health care providers caring for Arab immigrant women. A further benefit of the study is the potential empowerment of this population of women by having their voices recognized and included in research. Gocek, Balaghi, and Doumato (1996) indicated that women in the Middle East have used writing as a method to be engaged in their society and have this knowledge available to Western researchers and to the world. Consequently, this may potentiate an improvement in Arab immigrant women's health outcomes and a better quality of life.

Chapter Three

Engagement in Cultural Care with Health Care Providers

Engagement is defined as a response to the Other, a possibility of attaining full personhood by discovering one's full capacity in relationship. Within this relationship, the self is not challenged to hold altruism in opposition to egoism. Rather, the self attends to the Other while simultaneously attending to the self. (Goldberg, 2004, p.56)

Engagement in care is at the core of relationships between patients and their health care providers and is an entry point to the provision of effective and high quality care (American Health Information Management Association Journal (AHIMA), 2012; Carman et al., 2013). Engagement, where health care providers work with patients to address their needs, shows that patients are the focus of care (Carman et al., 2013). Coulter (2012) has emphasized that engagement is about building an efficient relationship with patients, one that enables those patients to play an active role in their health care decisions, not only at an individual level but also at the larger social level. Prinz and Miller (1991) have defined engagement as patient participation in treatment decisions that include attending sessions, actively collaborating during sessions, and active participation after the sessions in the treatment plan.

Engagement in care provision should encourage a higher level of active participation in organizational policies and decision-making (Carman, et al., 2013). This is illuminated by study participant Iman, who indicated that engagement and collaboration are needed between patients, departments, policy makers, and government to support each other with money and ideas. She stated:

> I know it would take a lot of time and collaboration between many departments; patients should have active roles and should be consulted. But I think it should start from the head department or, I do not know, the person who can make changes, give orders, and plan new strategies. There must be support from the government because this will need lots of money and extra budgeting.

Although building an engaged relationship with Arab immigrant women is important, it is equally important to understand how the concept of engagement in the Western World is seen by Arab immigrant women from different cultural backgrounds, as well as how health care providers who engaged with Arab immigrant women influenced the experiences of these women. In other words, the very concept of engagement—what this consists of, what it entails—may differ according to people's cultures. Thus, understanding the meaning of engagement from Arab immigrant women's perspectives is crucial for health care providers in the Western World in order for them to promote such engagement in health care environments.

This chapter, drawn from the storied experiences of Arab immigrant women in the context of emergency care, attends to the theme of culturally engaged care with health care providers. By understanding the ways in which culturally engaged care played a fundamental role for these participants in enhancing their experiences in emergency departments, health care providers may further recognize the importance of this embodied characteristic in provider-consumer relationships. In other words, when health care providers provided holistic care to Arab immigrant women, which included physical, emotional, spiritual, and cultural care, Arab immigrant women felt that this kind of care was embodied, as it fit with what they needed. They, in turn, felt that health care providers cared about them, and this enhanced the engagement process.

Engagement in the First Moment of Interaction

Goldberg (2005) and Tryon and Winograd (2002) and Walsh (2009) indicated that engagement has to be ongoing for a relationship to last for a long period of time. However, the 'initial moment' when health care providers approach their patients has an effect that is not easily forgotten. The way that nurses and other health care providers initially approach their patients may foster or hinder the engagement process especially when dealing with patients from different cultures, who may have different languages, different communication styles, and/or different ways of greeting. Various strategies have been offered to assist health care providers when first meeting patients from different cultures. These include approaching slowly, self-introductions, offering a chair in a quiet place, allowing sufficient time for patients to relax and ask questions, and self-disclosure, all while paying attention to the patients' nonverbal communication (Munoz & Luckmann, 2005). Sharing personal information or experience with others is called self-disclosure (McDaniel et al., 2007).

In Arab culture, Aboul-Enein and Aboul-Enein (2010) indicated that some Arabs prefer to talk about their general personal lives, such as where they live and what they do for living, when first meeting their health care providers, before discussing what brought them to the hospital. Arabs may feel more open when health care providers voluntarily discuss some aspects of their personal lives; some Arabs may withhold information and not share important issues with the provider if they ask a question and the health care provider is not open to self-disclosure in the first encounter. In emergency departments, patients feel more comfortable and their anxiety levels drop when they encounter nurses who, meeting them for the first time, open up to share personal information in busy moments. Such nurses were described as “brilliant” in Walsh's study (2009). Considering the nature of the work in emergency departments, health care providers need sophisticated skills to be able to initiate such conversations with patients (Arab immigrant women), while keeping their work going in a fast-paced environment (Bennett, 2013; Walsh, 2009).

This initial care is critical: Arab immigrant women may feel that their culture is being respected and the care provided is embodied, insofar as it is congruent with what they expect when approached in their preferred style. To “embody” means to provide a tangible and concrete form of an abstract idea or an act that includes body, soul, and spirit (Dictionary.com, n.d.; *Oxford Dictionary Language Matters*, 2014; Thomas, 2005). In other words, Arab immigrant women feel more relaxed when dealing with health care providers who self-disclose information about their families and jobs, and they feel that the care provided is holistic and embodied as it includes what is an essential part of their culture. When health care providers provide embodied care, they act in a way that is recognizable to Arab immigrant women, who feel the care received is congruent with their individual needs. This practice also helps health care providers to build a culturally safe environment. The first step to provide culturally safe care is to be aware that differences in beliefs, values, and world-views exist among people. Being sensitive to such differences and the attempts to address people's individual needs are gates to cultural safety (Main, McCallin, & Smith, 2006).

Safa, a participant in the study, mentioned that her relationship with her doctor in the emergency department started before she met him, as he knew who she was and what her problem was before approaching her; he had read her file, and she emphasized that his knowledge about her was essential to plan the care necessary for her and to establish a relationship that made her feel more satisfied. She stated:

> Then a doctor came, introduced himself, asking me how are you? and said "I am sorry, you had a miscarriage." [Silence]. But the doctor was so kind. I mean he apologized many times. He said that he knew that this was their fault because he saw my file before seeing me, and he knew that I had come earlier the same day, which is really great that he cared to know about me before coming to see me, so he had an idea about what to do.

Safa also mentioned that the doctor asked her, "How are you?" Cameron (2004) indicated that this question opens a gate to "a relational or a breathing" space, in a given moment, for patients and health care providers to share their stories and express their feelings. This question reveals the concrete knowledge of patients' bodies, lives, and realities needed to engage and provide appropriate embodied care. By asking this question, health care providers show their commitment to listening to and helping their patients by evoking "an immediate temporalization of bodily memories" (p. 57). This means that by asking "how are you?" Safa's memories were stimulated and she started to instantly and temporarily remember what happened with the other staff. The “How are you?” question makes patients state situations or express feelings that they have not spoken before. Safa, in her story, revealed that after the doctor asked her how she was, she became more open and discussed her sorrow and frustration. (This “how are you” differs from the “how are you” in social settings, as people do not intend to know any personal details, and the phrase is just a way of greeting, such as “hello.”) Safa stated:

> I told him that I knew the reason [of my miscarriage], and it was because of that nurse who did a vaginal ultrasound. She was really bad, and I told her: “It hurts. It hurts.” But she refused to stop. I said I think it was because of that nurse, so he apologized many times.

Safa blamed the nurse; however, she did not make this explicit until the doctor asked her how she was. In this story, the knowledge that Safa's doctor obtained prior to meeting her was concrete knowledge; it was thus embodied knowledge about Safa's body that enabled him to engage with Safa to provide the care she needed as an Arab woman having experienced a miscarriage. For Safa, engagement occurred with the doctor because of his kindness, his apologies, his questions about her feelings, and his knowledge of her conditions before seeing her.

Embodiment as Concrete Knowledge

In the concept of embodied care, the role of the body in healthcare delivery is emphasized in generating and maintaining the bodily knowledge needed for care (Merleau-Ponty, 1958/2005). Despite the importance of this knowledge to health care relationships, it is not always valued in the current delivery model, which often objectifies the person, reducing her/him to an object (Goldberg, 2002; Gadow, 1994).

This bodily concrete knowledge is the cornerstone of any medical relationship, as patients feel a caring attitude by health care providers when they treat their concrete bodily symptoms. This concrete bodily care is an integral part in providing holistic care that is felt by Arab immigrant women as embodied.

Rogaiah, a participant in the study, indicated that staff in the emergency department asked her certain concrete questions, did a physical examination, listened to her needs, treated her physical symptoms well, and left her feeling relaxed and cared for. To be relaxed means to lessen one's anxieties, worries, and tension; the physical body then feels less rigid and may appear less formal (Dictionary.com, n.d.; Oxford Dictionary Language Matters, 2014). Rogaiah goes on to say the following regarding her care:

> First, they took my blood pressure and asked me specific questions like "Do you have diabetes, hypertension, and allergy to medication?" . . . They took me to the doctor, and he examined me and did percussion on different places until he knew where the pain was. Right away, they listened to my needs and gave me an injection with an IV bag, and I gradually started to calm down. I was relaxed.

Another participant in the study, Meriam, gave detailed information about what was asked about, while she was in triage in the emergency department. Meriam's doctor also performed procedures that helped her to obtain the concrete information needed to provide the appropriate care that recognized Meriam's feeling and made her feel relaxed. Again, asking concrete questions and performing physical exams and laboratory investigations led to listening to Meriams' needs and making her feel relaxed. She stated:

> She was asking about my address, who was with you, and a list of questions . . . [that are] related to my existence in Canada, and my ID, study permit, and health insurance . . . she asked me about my family file, and to be specific, she asked me about the family doctor. [The doctor] took the history, then she . . . asked me some private questions… She took all the information, did x rays and tests . . . The best thing was when she asked me so I told her that I could not bear the pain, she then gave me a painkiller, and at least she listened to me, and listened to my needs. Really the painkiller made feel better, then I became more relaxed, I could not feel my body and no pain. So I had not a problem to stay on the bed.

Although the above examples illustrate the ways in which providers gathered information, both participants felt they were listened to and valued. Rogaiah and Meriam, in both their narratives, emphasized that knowledge obtained skillfully by their doctors to provide them with care met their needs as an embodied or complete person. This made them feel comfortable, cared for, and relaxed, which fostered their engagement with health care providers. Only through relational and concrete knowledge, built through communication, are health care providers able to “abolish the polarity of the two” (Goldberg, 2008, p. 81) and feel what their patients feel; to be able to care for Arab immigrant women; to be able to interact with these women's bodies, smells, sounds, and movements in order to build a caring environment where embodied care is possible, even with their different backgrounds (Hamington, 2004).

"When my body confronts another, even if it is a foreign body attired and socially constructed differently from my own, there is still a fundamental connection and understanding" (Hamington, 2004, p. 54). To obtain this kind of knowledge, verbal and nonverbal communication must take place between Arab immigrant women and their health care providers.

Engagement through Nonverbal Communication

Although knowledge is essential in the provision of embodied care, it must be accompanied with sympathetic feelings, passions, and affective bodily perception (Hamington, 2004). Affective "feeling" perceptions can be established through communication and interaction between Arab immigrant women and their health care providers. Communication plays an important role in any relationship and may enhance or delay the engagement process. Its importance is crucial in hospital settings because clear and unambiguous communication is necessary in order for the messages conveyed to be accurate, which in turn assists health care providers in providing treatment that is effective, safe, and culturally congruent (McGilton et al., 2009; Tsai, Tsai, Weng & Chou, 2013).

Health care providers should be aware of the communication style of the patient they interact with, as their awareness helps in building a therapeutic healthy relationship and in creating a positive engaging atmosphere. Arabs tend to be highly contextual in their communication (Aboul-Enein & Aboul-Enein, 2010), in which they rely more on nonverbal communication. They usually do not explicitly say what they want, and they leave it for the listener to interpret and understand what they need (Srivastava, 2007). This may make the experience harder for them when health care providers are not aware of this cultural difference (Aboul-Enein & Aboul-Enein, 2010), especially in emergency departments where there is little time for staff to deal with patients (Walsh, 2009). Nada, a participant in the study, described this highly contextual communication when she narrated how her experience would be different if a family member was with her, a person who understood her care requirements without the need for her to talk. For Nada, the prior knowledge that her family members had helped them to provide the care needed to enhance engagement, along with their support and empathy. She reported:

> [When people are sick], they need someone from their family to support them. A family member can empathize more than any other person, and they always seem to know what to do without me saying it. For example, if my mom or dad were with me, they would know that when I am sick, I feel drowsy and so they know exactly what to do. But my friends, they don't know what they should do if I did not verbally tell them.

Indeed, Hamington (2004) explains that care goes beyond verbal and direct communication and can be provided even with nonverbal communication when the interactions take place between two familiar embodied beings. This type of interaction is defined by Weiss as "embodied exchange" (1999) and by Merleau-Ponty as "intercorporeal" comprehension (1968). This relation is typically found between family members, who have corporeal (bodily) prior knowledge that enables them to attach meaning to certain movements and helps them to provide information to support health care providers in the best care for women based on the family members' background understanding of what needs to be done (Hamington, 2004;

Merleau-Ponty, 1958/2005). This indirect communication may cause tension between people from different cultures. For example, Western health care providers may not have understood what Nada's nonverbal communication meant, which may have decreased engagement opportunities.

Nonverbal communication gives stronger hints when dealing with patients who are culturally diverse and speak different languages, even though effective verbal and nonverbal communication both play an important role in the enhancement of the engagement process (Davis, 2000; Srivastava, 2007). Touch, facial expression, and gesture are three common nonverbal communication cues that nurses should pay attention to. Goldberg (2004) emphasized that touch and eye contact at the beginning of a relation between nurses and women could facilitate a respectful, engaging atmosphere, and that the way nurses and health care providers ask women about their histories show these women that the provider is focused on their needs. Rogaiah contended that smiling is an effective way to treat patients' suffering and enhance engagement. However, health care providers should be careful and genuine when smiling with patients, as it could be inappropriate to smile while patients are suffering. She stated:

> I wrote a message to the Ministry of Health, the presidents of every hospital, and the doctors to tell them that a simple and a first thing that you could do is to smile, which is a virtue in Islam. It should be the beginning of the treatment.

Rogaiah's words emphasized that smiling and kindness have an Islamic root. The prophet Mohammed “peace be upon him” said “If you cannot help other people by your money, your help can be attained by your smiling and kind attitudes.”

Not unlike Rogaiah’s experience, my own practice as a nurse in an emergency department in Saudi Arabia often showed how the power of a smile could inspire the patients' willingness to communicate and have a dialogue with me. I remember a woman who told me that she would never allow any nurse to examine her in front of students. Because of my smile, however, she not only allowed me to examine her but also allowed my students to practice with her. The smile opened up a space for a trusting relation where this woman in a moment of sickness and vulnerability was willing to share her lived experience not only through verbal communication but also with her body, allowing us to perform a physical examination.

Touch is a body language that reveals respect and power in some cultures. Culture usually determines what kind and amount of touch is appropriate in different situations and between different people. Gender and age may also influence the amount of permissible touch within certain cultures (Srivastava, 2007). In Arab culture, touch is preferred when dealing with some family members, such as husbands or mothers. Similarly, a female health care provider touching an Arab immigrant woman may be interpreted as showing empathy and thus may decrease stress. Even in the chaotic emergency environment, nurses' presence can make a positive difference in the nurse-patient relation in a way that fosters a patient’s engagement (Walsh, 2009). To be present means to be attentive to the needs of somebody else and to be an important and a special part of their experience (Walsh, 2009; Dictionary.com, n.d.).

Doaa, another participant in the study, described the care, the touch, and the relaxing tone that her husband offered her and how his presence in her space during her emergency stay made her experience much better. For Doaa, the nonverbal communication that made her relaxed and decreased her pain and discomfort was the warm presence of her family member and his talk, touch, voice, and physical help. Doaa stated:

> My husband was with me, and he played a great role in easing my pain and my discomfort. He was with me, talking to me, which made me feel relaxed. His touch, his warmth, [and] his voice tone … [made me relaxed]. He brought me a blanket, stayed with me all the night. I could not have a better care.

Safa also described the physical and emotional care that was provided by her family. This included everything from helping her while walking to the washroom to making jokes to lessen her stress and fear. Safa's example gives a small window into family support as enacted within Arab culture, where most of the family members stay together to support the family member during their hospital stay—often in the waiting area. Aboul-Enien and Aboul-Enien (2010) and Kilwicki and his colleagues (2000) described the importance of family support in Arab culture, including family support during hospitalization. This support by extended family members in Arab culture resembles what is found in some other cultures, such as Indians, Mexicans, and Asians' families (Cong & Silverstein, 2012; Nath & Craig, 1999; Sarkisian, Gerena, & Gerstel, 2006). Safa's story shows that collectivism is a characteristic of Arab culture. Individuals who value a collectivist manner in communication usually see their families as an integral part of their care (Dastjerdi et al., 2012; Davis, 2000; Srivastava, 2007; Wang, 2011). Although it may be challenging to have numerous family members in busy emergency departments, nurses and health care providers should be sensitive to patients' needs for extended family support, particularly when it does not interfere with their work (AlMutair et al., 2014). Similar to what Doaa considered to enhance her engagement and made her experience better, Safa explained that the presence of her family members, along with their emotional and physical support, helped with the long waiting time and made her psychologically feel better. Safa said:

> [There were] my husband, my two brothers, the wife of one of my brothers, and her daughter. Their presence was also important. At the beginning, I went with my husband. Then they came [afterwards]. I really benefited from them because I was not even able to go to the washroom, only with the wheelchair. So my brother's wife accompanied me, as I was not able to sit, she helped me to change my clothes. This was the first thing. Then I had to wait a very long time (six or seven hours). They waited with me, and then they left. It is similar [to what the other lady said]: their presence was really important. If I was only with my husband, he would be tired, as he is always fighting with the [staff] and I would be in more psychological pain. My brother was trying to make jokes and lighten the mood.

This kind of care is reflective of Merleau-Ponty’s understanding related to feeling and perception as necessary to the provision of embodied care. The importance of bodily perception, sympathetic feelings, and interconnectedness (Merleau-Ponty, 1964) were all emphasized in meaningful ways by Arab immigrant women in their stories. Support came not only from their family members but also from health care providers who were described as being attentive listeners, with caring voices, and relaxing influences in their provision of care. These emotionally intelligence skills in emergency departments are described to be amongst the most vital, as they lessen patients' tension while attending to their urgent physical situations (Bennett, 2013). Emotional intelligence means having excellence on caring and personal relationships that leads to success in social life (McQueen, 2004). The afore-mentioned attitudes and skills enacted by nurses and providers are gates to embodied care. They foster patients' relationships with health care providers and in turn influence patients' integral engagement with family members.

Meriam, another participant, described the way her nurse dealt with her as a sedative and indicated that engagement for her entails someone being nice, asking about her condition and pain, listening to her, and showing a caring attitude: "The second nurse came and she was so nice . . . she asked about the problem, and cared so much to listen attentively to my complaints, and asked me if I still had a pain in my neck. After that, I was relaxed, it was like a sedation." She also relaxed because of the way the ambulance men treated her that enhanced her engagement: their kindness and caring attitude, along with being alert to her condition and to the safety, calming her down, and respecting her. Meriam said:

> The two men noticed that I was drowsy because of the medication, and said to me, 'Don't worry; just relax and we will move you by the same bed.' There was my things under the bed, so they told me, "Don't worry, we will take it, we will go to that place. Do you want anybody with you?" They were asking me. I felt the care from the both men . . . They really cared to do their job in a right way. They cared a lot about safety . . . [The man] was not rough with me,

> and was with me step by step. He was really respectful . . . they were really kind . . . I was really relaxed to the extent that I fell asleep.

Iman was also impressed by the smile, kindness, friendliness, laughter, and manner of talking of the nurse that greeted her in the emergency room. Iman emphasized that these attitudes helped a great deal in lessening her anger and disappointment. Iman stated: “She [Iman’s nurse] was nice, laughing with us, talking about herself. She was really friendly. I could say the smile of the nurse inside the room helped me a lot in decreasing my frustration and anger.” Doaa echoed what other participants said and emphasized the positive effects that good treatment by being nice and smiles from the staff had on her experience: “They were kind and smiling. [A positive thing was] the way they dealt with me with a smile on their faces.”

Paying attention to the face shows respect and enhances engagement. Cameron (2004) contended that by paying attention to the face, health care providers can better interact with patients and respond to their needs. It signifies a relational communication between patients and health care providers. Rogaiah indicated that the staff in the triage area were able to address her needs and approached her quickly because they paid attention to her face and recognized that she needed urgent treatment. She stated:

> When I first entered the door, they immediately came with the wheelchair and took me directly inside. Oh my Holy God, even though I did not complain at all, I kept my pain inside. However, they maybe saw my face really pale and weak and looking like I was about to scream.

Doaa was also paying attention to the health care provider's faces and facial expressions: “The way they dealt with me with a smile on their faces [made my experience really good].” Doaa's words also indicate that facial interaction is relational, which Cameron (2004) and Vouzavali and colleagues (2011) have also emphasized: “Nurse and patient reveal themselves to each other through a mutual gaze that encompasses each other’s world care and intimacy are conveyed … Through the mutual gaze, a deeper communication and mutual understanding are achieved and a bond is developed” (p. 146). Cameron (2004) further explained that paying attention to the face is an ongoing process throughout the course of treatment. Patients and health care providers thus “interface as they work through the complex knowledge required to make decisions” (p. 58). This interface shows respect and promotes engagement within “a conversational space” (p. 59).

Looking into someone's face while in conversation, in Arabic culture, reflects respect, and, consequently, helps in building a trustful and engaging environment. However, some women may avoid eye contact when dealing with male health care providers (Hammoud, White, & Fetters, 2005). Therefore, health care providers should be aware of these cultural differences in order to enhance engagement.

Through communication, health care providers can enhance their awareness to provide safe and congruent care (Zavertnik, Huff, & Munro, 2010) that is both culturally congruent and ensconced with a caring attitude (Brown, 2009; Poortinga & Pedgeon, 2003). Rogaiah emphasized what she wanted in care provision. She was looking for somebody who examined and felts her pain, attended to her needs, and rechecked on her from time to time. She wanted:

> Somebody who cares, someone who examines my pain and transfers me to a specialist when it is needed, somebody who feels my pain. My doctor did. My doctor was excellent. He examined me and kept coming to ask me if everything was good. Even though it was an emergency, he was moving around from patient to patient to check on their conditions.

In this story, the doctor attended to this woman's needs by checking on her condition frequently. His attitude reflects his patience and commitment to help patients and to be engaged with them. In the next section, I discuss how patience is an important aspect of providing engaged care by continuing Rogaiah's story with her doctor. For example, Rogaiah's story shows us that stories shared by these Arab immigrant women about their lives and culture allow health care providers to understand hidden cultural practices in ways that providers may not have previously been aware of. Such cultural practices require explicit communication between a particular population and their health care providers. Thus nonverbal communication does not negate the integral role of verbal communication in providing engaged care to Arab immigrant women. "The nurse's use of competent language and expressions is more likely to engage the patient in a dialogical discussion that brings forth an open, honest display of feelings and emotions" (Finch, 2005, p. 251). Hence, it is only through conversation that nurses are able to understand and interpret the cultures, beliefs, and values that construct patients' realities and lived experiences (Finch, 2005).

Engagement through Patience in Provision of Cultural Care

Patience is an additional attribute needed to help health care providers see their patients as themselves, which consequently helps them to provide engaged care (Walsh, 2009). According to Goldberg (2008), "Patience demands tolerance, empathy, and care. It forces us to see the *Other* as ourselves" (p. 81). Rogaiah, explaining this point, stressed the importance of patience and tolerance when treating a patient, emphasizing that patience seemed to help health care providers to understand her culture and to help her when they met with language or communication barriers. She said:

> They understand. The more they see us and learn how to act and reflect our culture, the more they understand. They are free, but they learn. They understand. When I went there, I just asked for a female doctor to examine me. Then I went back to my male doctor. [Laugh.] Then they brought a female nurse . . . Even though I speak English, I was not familiar with the medical terminologies. But when I did not understand something, I asked them to repeat it slowly and they did. They repeated three or four times in a different way until I got their message. I let my daughter interpret, but the doctor told me that I speak very good English. I was more cautious, though, and wanted my daughter to be with me. So he laughed. [Laugh.] You know, it is not my first language, especially with medical terminologies… It was good that they repeated the information so many times and tried to make it simpler until you got it if I did not understand. They have patience, tolerance . . . This was the thing I liked most about them.

Rogaiah's words reflect how satisfied she was with the care provided when her caregivers had the patience to work with her, to respect her cultural differences and be willing to learn her culture in order to understand the differences between the two cultures, and to listen to her needs by repeating the information in different and simpler ways. Practicing patience and tolerance enhances a trustful relationship between Arab immigrant women and their health care providers, which helps in taking the relationship to a more advanced level of engagement. Rogaiah's narration further indicated that her fluency and confidence when speaking English in her routine daily activities were compromised when it came to medical language and terminology in times of stress and anxiety while she was in the emergency department.

In emergency departments, health care providers often do not have sufficient time to spend with patients who have limited English skills, which can frustrate both the care provider and patient (Srivastava, 2007). However, Rogaiah's doctors were committed to help her with her limited language in order to improve their relation and to foster engagement. Even though patience is more than a technique or a strategy as it also includes learning from others, using simple words, repeating information, speaking slowly, and using pictures and gestures to help patients understand are effective strategies that health care providers used with Rogaiah, strategies that showed their patience and helped build an engaged relationship. Trust is the ultimate result when health care providers establish a relationship like the one Rogaiah built with her provider.

Trusting Relations and Engaged Care

The honesty and integrity of nurses and other health care providers leads to building a space filled with trust (Goldberg, 2008), which enhances trust in the Canadian health care system as a whole. Brown (2009) has emphasized that trust is built through interactions between patients and health care providers and that this interaction involves an encounter of “vulnerability and uncertainty” (p. 391). Davis (2000) and Munoz and Luckmann (2005) indicated that culture influences the amount of information that patients want to share with others. When they build trust, however, they are open to disclosing information to their providers and to engage with them. In order for patients to trust their providers, health care providers should not only listen to the patients' voices but also encourage them to express their needs and have their voices heard. Further, both patients and health care providers should have the ability to interpret what has been said in ways that build “a communicative trust” (Yatchmenoff, 2005). For example, Nada, in the context of the study, indicated that her interaction with her health care providers made her lived experience in the emergency department positive. This occurred because of the freedom and the ability to choose that nurses gave her, which in turn built trust in the system as a whole. The nurses were not strict with her with regard to time and what she had to do. For example, they did not give her a strict time to change her dress and did not tell her to sit in a certain area or to wear a certain number of gowns. They rather gave her the ability to choose the number of gowns she wanted to wear. Respecting her privacy by offering extra gowns was another experience that contributed to Nada's trust in the system. She stated:

> They interacted with me in an excellent way. I felt relaxed when I entered to take the x-rays. They didn’t tell me to do this or do that. They just let me do whatever I wanted . . . [The system] respects [women's] privacy, especially with regards to the way they dress. I mean, I cannot go out like this, how I can go like this? So he knew it by himself, and gave me another cover in order to cover myself. This is why I really trust this system.

Based on her positive experience with nurses in the emergency department, Rogaiah echoed what Nada said and built a trusting relation with nurses. Rogaiah emphasized that her experience was better and that she trusted the system because of the fast service and quick treatment by nurses and doctors, their ability to listen to her needs and questions, their patience by giving her enough time to get the needed treatment, and the caring attitudes they had when approaching her. She concluded that nurses played a strong and important role in a system devoted to attending to the needs of patients. She said:

> I felt really comfortable psychologically. At the beginning, though, I was afraid. My friends had made me afraid by telling me about the long wait. So the first thing that made me comfortable was the fast service. My pain was also treated quickly. They gave me enough time; they were not in a hurry. They did not say: “That is it, now you have to go! Go!” They did not hurry in anything. Instead, I was the one who was asking them if could go. [Laugh.] . . . Here, they would not feel good unless the patient left not as sick as he arrived. This gave me confidence in the system. I could ask them whatever I wanted and they answered me. I came with pain and the ones in the triage were in a hurry

> and took me in a wheel chair. I sent them flowers, to all the staff. They were really good. I told my daughter that they were really angels of mercy . . . I was really drowsy, so I entered immediately and the doctor with the nurses came right away. All of the staff came in a hurry. They were all standing over me. So I was thanking my God. They were really the angels of mercy . . . nurses here have a role much more important and a stronger role than doctors, because they are the ones who are taking care of the patients.

What Rogaiah explained regarding her engagement with the health care providers was emphasized by Staudt, Lodato, and Hickman (2012). Staudt and colleagues (2012) asserted that engagement starts with the first contact with the receptionists or even with the referring staff. However, such engagement may continue after patients' discharge—as indicated when patients send flowers or cards to health care providers. The way that health care providers approached Rogaiah with confidence that they had the competency to help her and address her cultural needs fostered her trust and consequently the engagement process. Further, Rogaiah stated that her providers were not in a hurry, which is central to providing engaged care and thus contributes to the building of her trust, as emphasized by Cameron (2004): “If we rush too fast to an answer, we lose the momentum in the language; we are cut off” (p. 54). Therefore, a basic strategy when dealing with a patient from a different culture is to give her/him enough time to respond, especially when the person speaks a different language. This is particularly important as the person (patient) requires sufficient time to interpret what is said and find a response in English (Srivastava, 2007). This also emphasizes the need for patience when dealing with patients from different culture. Emergency nurses, for that reason, need to balance their time in order to give patients the time needed without compromising their workload (Bennett, 2013; Walsh, 2009).

Brown (2008) and Williams (2008) have contended that for a trustful relationship to exist, health care providers must put patients' benefits ahead of their own. Nada and Rogaiah in the above stories, in their interactions with nurses, described how nurses appeared to place patient needs and benefits as the priority, despite their different cultural backgrounds.

Consultation, which is considered a first level of engagement in a study by Carman and colleagues (2013), takes place when patients receive information about their diagnosis or procedures. Rogaiah contended that the information she received about her treatment enhanced her comfort and trust in her health care providers and in the system as a whole, as the given information enabled her to make informed decisions and consent. She revealed:

> They told me their names and why they were with me. Then they asked me about what brought me to the emergency department. They told me why they were with me and what they were doing. You should have an idea what was being done. It was essential, so they would know if you agreed or not. After the registration and after taking the information, the nurses were with me. They explained everything in detail. This really made me comfortable, and I really trusted them.

Telling a patient what she/he can expect to happen and whether the procedures might make her/him uncomfortable further facilitates a trusting relationship and ultimately the engagement process (Carman et al., 2013). Safa, for example, indicated how the doctors anticipated and empathized with her pain and told her how the procedure could make her feel, and how they were apologizing as they were causing her more pain. Surprisingly, for this reason, Safa preferred male to female doctors:

> I feel that here in Canada in general, when I deal with men in the medical field, they are much better than women. I had more than one experience. I felt that men are more caring [and] their way was better than women . . . I felt that they did their work, but at the same time they cared very much about their patients' psychology and feelings. Like before, when I did the ultrasound, the men were really caring. There were two of them. Even when they would press or push on my abdomen, they told me: We will do that and you will feel some pain, and we are really sorry. So they were apologizing all the time, although it was their work, and the pain was coming anyway.

In summary, when health care providers interact with Arab immigrant women in emergency departments with honesty and a willingness to listen to these women's needs in order to improve their experiential lives, a trustful relationship is fostered, which facilitates the engagement process.

Respect and Engaged Care

Three main characteristics viewed by participants as indicative of a respectful attitude were self-introduction when first meeting Arab immigrant women, attending to their cultural preferences and fulfilling their individualized needs, and being noncritical when Arab culture interferes with Western health care practices. “Respect” means the acknowledgement of a basic human right that a person has, by which the person feels honored (Dictionary.com, n.d.; *Oxford Dictionary Language Matters*, 2014). Although respect can be defined in diverse ways, Feri and Shaver (2002) defined the characteristics of a person who is considered respectful, which includes being loving, caring, non-judgmental, honest, and listening attentively. Iman suggested that health care providers showed her their respect by telling her their names: “the doctors and the nurses who were inside (not in the triage) introduced themselves in a nice way. They told me their names with a smile. I know who they are and I felt that they respected me and are willing to treat me also with respect.” The exchanging of names is an entry gate to engaging with women patients, as indicated by Iman in the above example. “To call the Other by name reveals an intimacy, and conjoins the two as one in the experience”; calling a woman by her first name shows respect and is also a standard practice (Goldberg, 2004, p. 64). This is also connected to engagement in the first moment of interactions, which emphasized that a caring attitude and good treatment in a first encounter enhanced not only engagement with health care providers but trust in the whole system.

Although Benner (1994) did not explicitly explain that culture plays an important role in providing respectful engaged care, her theory suggests that culture is an essential component of care. Benner determined that care can best be provided only when narrations about patients' contextual lives and their individualized practices are discussed with their health care providers, who can then provide embodied care based upon individualized patients' culture. Likewise, Goldberg

(2005) and Staudt and colleagues (2012) explained that individualized care provided by nurses who ask women specific questions about their lives shows respect to these women.

Health care providers must be able to understand the diversity and the social contexts that form Arab culture to serve Arab populations in general and Arab women in particular. Understanding specific cultural differences and the resulting personal preferences of women from other cultures points to the need for effective communication (Hammoud et al., 2005); such understanding also shows respect for the aim of providing culturally congruent care.

Nada, one of the participants in the study, indicated in her story that she shared her cultural preference with her doctor, who was engaged in her care, respected her unique needs, and provided what she required. She narrated: “I told him [the doctor] that I could not let him see that part of my body and he said: ‘That’s okay. Just put a cover over it and I will be behind her to direct her [the trainee].’ He respected our culture.” Health care providers taking the lead when asking patients what they prefer is a sign of respect to the unique needs and humanity of patients, as well as a respect for diversity even among individuals within the same culture. This approach reflects the ability of health care providers to provide individualized congruent care and is also an advanced level of engagement with patients (Carman et al., 2013). When patients' preferences and decisions are implemented, higher levels of partnership and shared leadership occurs.

For Nada, doctors and nurses taking the lead by asking questions about her preferences by the showed their respect for her culture. She stated: “They respected them [my culture and my religion], as I told you, he was the one who asked [about the need for extra cover] and brought me the two covers." Meriam also considered the question about her food preference a sign of respect for her culture. She reported: "They did ask about food restrictions. They asked me if I eat meat if I drink buttermilk, milk. This is also showing respect for our culture."

Being nonjudgmental and sensitive to patients' needs are additional characteristics of health care providers in emergency departments (Walsh, 2009) who are considered respectful (Drew & Dalhberg, 1995; Staudt et al., 2012). Meriam described how her health care providers were respectful when they did not judge the way she dressed and when they did not invade her privacy. She said:

> They respected my culture. They did not judge by the way I dress. No. nothing like that . . . As I was wearing head cover, I had not been assaulted on my privacy, or asked to take off the head cover or open the curtains when I closed them. I did not see this stuff.

In Arab culture, to consider another example, some Arab women prefer that their health issues and concerns, and even their consent to some procedures, be discussed in front of their relatives (Hammoud et al., 2005). This Western aspect of treatment by her doctor in the emergency department, however, really impressed Meriam and she thought that this strict rule regarding privacy and ethics showed her respect and dignity to her humanity. She reported:

> They really care about ethics. For example, when the doctor came to make the assessment, there were some confidential questions about my marital status, and my daughter was with me, so she asked her to leave. I told her that I had

> no problem with her being with me. However, she told me even if my husband was here, she would ask him to go out. They cannot ask such questions in front of others, even if I agree that they stay. This is a regulation they have in the emergency department. It was not about culture, but ethics. Nobody should be with you when these questions are being asked, just you and your doctor. I really still think about it. You feel that there is respect, dignity, and value for your humanity.

Although this practice could be considered as offensive and non-respectful, as some Arabs considers decision-making to be collaborative and questions to be asked and answered with certain family members around, Meriam indicated that this situation fostered her engagement with the doctor and made her experience better overall. She felt that her doctor respected her as a human being when she maintained confidentiality. The doctor in this narration did not judge Meriam for asking her to let her daughter stay. Instead, she was neutral and advocated for Meriam's rights by explaining the role of health care providers in maintaining patients' confidentiality. Meriam's words force me to think of my own practice as a nurse: even though it is a social norm in Arab culture to share stories or ask questions in front of relatives, Arab women may feel more power and more respect if I, as a nurse, protect their privacy by asking the relatives to wait outside while assessing and asking questions. I might also reflect on the policy as both a nurse and Arab woman and consider if it fully reflects the cultural complexities and diversities found in Arab culture that may find support in family participation during questioning by health care providers, even when such questions are of a confidential nature.

Throughout this chapter, I illuminated, through the analysis of the Arab immigrant women's stories, how some practices by health care providers promoted their engagement with Arab immigrant women, which improved these women's lived experiences in emergency departments. Kindness, smiling where culturally appropriate, showing concern, empathy, and support by providing efficient treatment and health care information were articulated as health care qualities for supporting engaging practices with the women in the study. Further, the use of appropriate touch, being non- nonjudgmental, respecting privacy and culture, listening to the physical and emotional needs of the women, and and having prior knowledge by reading patients' files before approaching them were also described as important factors that contributed to Arab immigrant women's feeling of comfort and relaxed as their tension, pain, and anger decreased. The aforementioned practices are aligned with the provision of holistic and embodied care, and according to participants, led to the provision of engagement in emergency care. However, cultural difference played an integral role in how this engagement process was shaped. In the next chapter, I discuss how the lack of such practices led to disengagement and the resulting implications when disengagement occurred in the emergency department in the context of the study.

Chapter Four

Disengagement and Cultural Care

I don't remember them telling me anything about themselves. I don't know if they were nurses or something else, like aides. I don't know. She jumped right away to the questions about me and what brought me there . . . [Their interaction] was formal, so I can't really say if they were nice or not. They weren't friendly, but they weren't rude, either. They were just doing their job. They did not treat me in a way that made me feel that I was the center of their care, as we always hear about care delivery, and I was not an important decision maker in my treatment. I felt that there was a distance between me and them, and they had the authority over me. The place was uncomfortable. They did not smile, did not tell me their names, did not look at me, did not care about my culture and what I needed; I did not even know who they are. As I told you, I felt that it was like I was invading their private space where I was extremely not welcomed. (Iman, study participant)

Iman's words reflected her disappointment while sadly sharing her first moment of interaction with paramedics in the triage in an ED. Although her later experience in emergency care was positive with providers, as indicated in the previous chapter, this particular interaction was not so positive. The health care providers did not introduce themselves by name and job title, did not smile where appropriate, did not care about her culture, and did not disclose any personal information with her, which produced a space of power imbalance and authority over her. Further, their interaction was focused on her personal information rather than on her emotions. This type of interaction prevents the evolvement of an engaged relationship that would assist providers in understanding the lived experience of this Arab immigrant woman, which in turn would help them provide the embodied cultural care needed. A physical and emotional interaction is needed to connect with Arab immigrant women's lives and affect their emotions in order to make them feel comfortable and welcomed, even if they feel horribly sick in an unfamiliar place. Unfortunately, in the story mentioned above, the chance to understand the life of a woman who came from a different culture and who may have had different needs was lost.

In this chapter I present how cultural differences between health care providers and Arab immigrant women played an integral role in miscommunication, which resulted in disengagement. In doing so, I draw on stories shared by Arab immigrant women to reveal their experiences when they visited EDs for the first time in HRM. Some suggestions for EDs in Nova Scotia are also included in order to improve the experiences of Arab immigrant women and to better facilitate their access to the provincial health care system.

Disengagement and the First Moment Interaction

Granger (2013) has demonstrated the crucial importance of having health care providers properly introduce themselves when initially approaching their patients, to facilitate the engagement process. This has special importance when dealing with Arab immigrant women, who come from a culture where some women do not have the power to initiate a conversation and feel less powerful when dealing with health care providers. Further, Arab immigrant women speak a first language different than that of most Canadian health care providers, which makes speaking slowly while introducing a name and a job title very important. Granger (2013) further argued that health care providers know a great deal of information about their patients; if patients do not at least know their providers' names and positions, a power imbalance is created, potentially producing an environment with distrust. Therefore, when health care providers do not introduce themselves, it not only prevents positive engagement with patients, but further confuses patients regarding the role of those providers.

Safa, a participant in the study, who was not familiar with the roles and settings of EDs in Canada, thought that the one who treated her in a rude way in the triage area was a nurse, and she wondered how a nurse could deal with her patients in this manner. In this case, the staff member was not a nurse, but as she did not introduce herself by name and by her job title (Miller, 2002), Safa was not able to differentiate between nurses and other health care providers. Safa was waiting in a wheelchair with severe pain and bleeding, and she was crying. The health care provider was very rude when dealing with her and did not care about her emotions; the provider solely focused on her physical symptoms. Safa stated:

> Then they told me to wait in the waiting area. I waited really long, to the extent that I had a really severe bleeding and some tissues started to come out from my vagina, and I was crying all the time. And they saw me in a wheelchair and in severe pain. So I told them: “I am in really severe pain, please let me in, in a hurry.” But the nurse there was very rude. She told me: “If you want a pad, I will give you a pad. Wait in the waiting area.” And whenever I came to them, they told me the same: “If you want a pad, we will give you a pad. Wait in the waiting area. There are people who are more critical than you.” So I waited in

> the waiting area. [Silence.] I do not know how a nurse could not care for patients and be rude with them.

Similar to Safa's story, Meriam, another participant, indicated that she was in severe pain, angry, and did not feel she received the care she needed. She was also uncertain about the role of the health care provider as the staff member in the triage area did not introduce herself, focused on the screen, did not look at her, and was paying attention to her physical and personal information, not her emotions; Meriam interpreted this as a non-caring attitude, which hampered her engagement with this staff member. Meriam shared this story:

> There was a nurse there or that person who took the data. I do not know if she was a nurse or not, but she was wearing a lab coat. But she did not introduce herself if she was a nurse or not. So I do not know . . . They didn't concentrate, when asking, on my pain, or my complaints . . . They did not introduce themselves in a way that showed you that they cared about you…Their problem was focusing on my information and if I am here legally, and if my documents were complete . . . I did not feel they cared about me at all. They only focused on formal procedures, not my personal health. So it was not a good experience at all . . . Can you imagine a pain, a pain in my kidney. . . not a mild pain, all this time the pain was increasing and made me upset while the nurse (the paramedics) there was asking me. I wish she would say "Would you like to have a seat and relax" in a friendly way, but she was just concentrating only on the screen and filling the application. She did not even look at me or

> make eye contact. I wish they could change this thing and care about people who have severe pain and to ease it.

The staff member in this situation focused on technology and the system's requirements for information to enhance patient care, ignoring the most important aspect of care, which is patient-centered care. McConnell (1997) asserted that technology could decrease the quality of care provided as nurses overlook their patients and do not spend the time needed to talk and listen to patients, which hinders the engagement process. Thus, technology can override human interactions that establish engagement. The current system's process can make health care providers feel a lack of control and under pressure to speed the flow of patients in the EDs. As a result, health care providers may not have the needed time to care for patients' emotions. Nurses and other health care providers working in EDs should, however, have the skills to concentrate on multiple tasks. This entails the ability to listen to patients, calm them down and empathize with their pain, work with machines and technology, and be as quick as they can without overlooking the quality of their work (Bennett, 2013; Greenwood, 2013).

Even though participants felt the integral importance of “introductory engagement“ with their health care providers in EDs, they tried to find answers and explain possible reasons behind the uncaring attitude and the demeaning behavior of some health care providers. A busy work environment in EDs combined with a heavy workload and understaffing could be reasons for such an attitude (Granger, 2013; Staudt et al., 2012). Safa said “It depends on the workload. If they are overloaded and lots of patients come in, they might feel overwhelmed and want to finish with each person quickly. Sometimes, they do not even answer all of my questions. They just want to do their work. It was maybe the pressure”; Nada also agreed with what Safa said: “Yes, exactly. Maybe the number of staff at night cannot deal with the number of patients.” Staudt et al. (2012) illustrated that the amount of work and the time limit that health care providers have with their patients affect the psychological status of the providers in a way that prevents them from fully concentrating on their patients. This, in turn, influences the engagement process and the ability to provide embodied and culturally safe care.

The limited time that health care providers have in EDs may threaten the practice of cultural safety, as health care providers do not spend sufficient time to communicate and address the specific cultural needs for these individuals. The workload and staff shortage were not, however, in the hands of the caregivers. Agencies and organizational structures, policies, and resource allocation play a crucial role in forcing caregivers to be under pressure (Carman et al., 2013). Thus one must then ask, how it is possible for a provider who is not taken care of, to care for patients efficiently? Nevertheless, Rogaiah, believed that doctors and other health care providers should not have an excuse for their rude behaviors. She argued that if smiling is not the way health care providers deal with patients, then these hospitals should be closed. With her words, she reflected her frustration and anger at the situation:

> I argued several times with . . . doctors. I told them: “I am a patient and I am very sick—why you are shouting at us?” This is a patient who needs care, a relaxed environment. He is sick, he is not feeling good. You are doctors. You

> do not have to make any excuses. You must be smiling, be patient. Otherwise, you close this hospital and go back home. This is a shame. Why do you look angrily at him? He is a patient. There must be a revolutionary movement for these human issues, not for governments and useless things. Religious virtues are not there anymore. What happened may be a kind of God's wrath.

Rogaiah, in her story, emphasized that patients need a caring environment, with health care providers' smiling and patient, to help them feel relaxed and to enhance the engagement process. Shouting, along with a lack of smiling and patience, were seen by Rogaiah as a shame and contributed to patients' disengagement with their health care providers. In the next section, I illustrate, based on stories shared by Arab immigrant women, how the disengaged attitude of health care providers affected their abilities to provide holistic care to Arab immigrant women.

Disengagement and Individualized, Holistic Care

Mayeroff (2011) emphasized that to care for another is to respond to the individualized unique needs of the other in order to connect with another and to feel their presence: "The sense of identity in caring involves awareness of difference, and the awareness of difference between the other and ourselves involves a feeling of oneness between us" (p. 47). In other words, for health care providers to care for their patients, they should be aware of patients' unique needs that differ from their own need. By knowing these differences, health care providers would have the awareness to feel other peoples' suffering as if it is their own. If we care, then we are ready and willing to learn more about the uniqueness of the person cared for. Nurses who are not prepared to recognize the importance of the uniqueness of individuals and their cultures, as well as the importance of providing culturally appropriate care, cannot be effective caregivers in a multicultural society such as Canada (Davidhizar & Giger, 1998; Hammoud et al., 2005; Kridli, 2002). For example, Meriam described how her culture and specific individualized needs were not taken into consideration when health care providers dealt with her, which prevented her from engaging with them, and consequently the care given was not at the level that Meriam expected. Meriam stated:

> [Their way] was not so bad, but it was so formal. Like you are dealing with someone who doesn't know anything about pain, or about health-related issues, as they did not understand what the needs of a person who came from another place that has everything different . . . it was not at the level of a patient and a nurse, or a patient and someone who is working in a health field, or working in a place where he should know what pain means, what are the specific needs of a patient…there was no care at all. I felt that they were doing things because they had to do it. They had a list, a list of things to do, but it was not because I was a patient and I came here, no . . . I think there was nobody [who] cared about me, the whole issue was that I was just a number between so many numbers that entered this place.

Meriam described how staff in the triage area dealt with her as a 'number' who entered the ED and had to follow a certain procedure. The caregivers treated Meriam as an object, as a body that did not have unique needs that should be addressed (Merleau-Ponty, 1958/2005). Health care providers did not deal with her as a whole and as a body that consisted of all of its parts, which reflects the foundation of nursing practice as well as a phenomenological view of the self (Goldberg, 2002). They instead dealt with her as a machine or as a number, as she indicated in the narrative above. For Meriam, disengagement occurred because of her health care providers' lack of a caring attitude, lack of knowledge about her culture, lack of concern about her unique needs and of her pain, and lastly a formal manner that appeared to reflect their lack of understanding and/or concern about what a patient-health care provider relationship entails.

When health care providers deal with their patient as “the Other” who is not more important than the bed they are lying on as indicated by Hamington (2004), then their ability to engage and to provide embodied care to those patients is diminished. When health care providers do not allow for the “I and you” relationship to form into a relation where “I can feel your pain as mine,” engagement is impeded (Hamington, 2004) and patient satisfaction is decreased. When health care providers feel the pain of their patient as their own and at the same time are able to provide the needed care as they are able to distinguish themselves from patients, they are empathizing with their patients (Campbell-Yeo, Latimer, & Johnston, 2008; Goubert et al., 2005; Vouzavali et al., 2011). This empathy or “emotional detachment” is what needed to enhance patients' care and engagement, which is opposite to sympathy where health care providers lose the control over their emotions by over-reacting to the patients' pain and suffering (Wath, Wyk, & Rensburg, 2013).

What Meriam said is echoed in Safa's words when she described the treatment that she had received from her nurse, and how she continued the procedure in a way that caused her more pain and dehumanized her needs. Safa stated:

> The nurses were too rough and rude. The cause of the problem was when they took me to another place and the nurse there was doing a vaginal ultrasound. It really hurt, and I told her: “It really, really hurts. Do it in a gentle way.” (Crying sounds.) But she said: “You are not used to having this pain; it is normal.” It really hurt, to the extent that I told her to stop once but she completed it anyway. She did not care about my needs as human. At least, she should say something nice.

Safa, in her story, indicated that disengagement took place when the nurse did not empathize with her pain, did not listen to her unique needs when she asked the nurse to stop the procedure, did not care about her emotions, and did not interact and communicate nicely with her. Safa described these attitudes to be rude and uncaring, which caused her pain, and she thought that this was the cause of her bleeding and miscarriage. Saying something in a nice and kind way was interpreted by Safa as a caring attitude that could have made her experience better, which emphasizes what was discussed in the first theme about how verbal communication plays an important role in the engagement process.

These two health care providers, as seen by Arab immigrant women, failed to provide the holistic care that takes patients' psycho-social aspects as a main domain in providing patient-centered care, which promotes the engagement process. They did not incorporate the “effective treatment of patients [that] calls for a holistic approach that frames disease within the context of the patients' lives and experiences and does not view patients as purely biomedical entities” (Dawood, 2005, p. 22). In these two stories, the special needs and experiences of these two women were diminished to generalities, “rather than being understood as distinct and unique individuals” (Goldberg, 2004, p. 67). Meriam thought that this was maybe “her way of treating all of her patients.” She also indicated that “from my experience, it is not because you are Muslim or Arabic or are covering your head or not. Even Canadians complain about it. As a nurse, I was discussing these things with others and found that the same treatment that happens to us is similar to what is happening to Canadians. At the level of emotions and empathy, it is more difficult for us, as we come from an environment that loves care and empathy.” Meriam in her statement differentiated between the experiences of Arabs and Canadians with such nurses at the emotional level, and she emphasized the need for more empathy and emotional involvement when dealing with Arabs and Muslims. Hence, when a nurse deals with Arabs in a rude way, their experiences would be harder than those of Canadians. Meriam related this need to their culture that places a high value on emotional connection with others. In Meriam's case, health care providers developed non-caring habits (Hamington, 2004) that may have resulted from their busy and overloaded work environment, where they dealt with their patients with an uncaring and unprofessional attitude. Meriam also mentioned an integral point about the unique expectations of care and empathy for Arabs, insofar as these qualities are significant in their culture and regrettably not taken into consideration by staff.

In reflecting on Meriam’s comments within the context of my own nursing practice, I began to consider her concerns, and if providers were treating everyone according to their unique needs, or if being Muslim or Arab would result in the difference specifically related in the above example. I reflected on my own ability to provide culturally safe care to patients—care that is based on their unique health needs and that respects their race, religion, color, and cultural beliefs and values. Manchester (2013) emphasized that for nurses to be able to provide culturally safe care, they should be aware of issues related to gender, age, religious and cultural values and beliefs, world views, and health needs of people from different culture. Further, nurses need to avoid generalizing their view of a culture and should be attending to an individual's unique needs. This, however, could be more challenging when patients speak a different language. In the next section, I illuminate how language and culture played integral roles in the miscommunication between health care providers and Arab immigrant women who visited EDs in HRM.

Disengagement and Cultural Verbal Miscommunication

Verbal communication is an integral component of the nurse-patient relationship. With it, nurses and patients are able to express ideas, feelings, information, and challenges (Kirk, 2007; Munoz & Luckmann, 2005; Nordby, 2007). Arab immigrant women speak languages other than English; their worldviews, lifestyles, cultures, and beliefs may affect the way they understand or interpret the meaning of a spoken word. Although all participants in the study spoke English, they may say things in a way that was interpreted by health care providers differently. For example, Meriam clearly described how a nurse shouted at her when she complained of a pain in her neck while the nurse was injecting a medication. The nurse did not stop administering the medication or try to ask Meriam in more detail about her pain and her feelings. If this nurse put herself in the patient's position, she would not have dealt with her in such a manner. Meriam said:

> The second one was a registered nurse who was old. She understood well what she was doing, but she was not nice. She was tough with me . . . When she gave me the painkiller (I do not remember what its type) it was so strong, because I felt pain in my neck, there was stiffening in it. So I tried to explain to her that I felt pain, because I was scared from it. Instead of asking “where? How was it?” She just replied me “What you mean?”, “What you mean?” with a loud voice and anger. I did not fully understand why she was shouting. I had to tell her my feelings, she didn’t accept me to make any complain, I just wanted to tell her that I had a problem from the painkiller, because it was really strong . . . I just stopped talking as I did not understand why she was shouting. She should asked how? Where? At least, she should stop giving the medication . . . She should stop the drug and ask me exactly what I was feeling, then make an assessment. She did not care about this, she took the words as I was telling her “do not do it,” and she completed the procedure in a way that I saw wrong.

In this situation, talking with a loud voice, shouting, anger, and being tough with an uncaring attitude, in the way that the nurse dealt with Meriam, created a misunderstanding that led to a disengaged space, where Meriam distanced herself from the nurse by avoiding further communication. This subsequently did not lead to providing the care needed. Meriam explained that she thought the nurse interpreted her words in a way that was different from what Meriam actually meant. Thus, health care providers need a clear understanding of what a patient means, and nurses should have the patience to aim for this even in a hectic environment, such as an ED.

The engagement process could also be influenced by the patients' own lack of willingness or desire to communicate with health care providers; this emphasizes the reciprocal relationship between caregivers and patients (Carman et al., 2013; Staudt et al., 2012). Patient-staff interactions are two-way communication processes. Meriam underscored that even though she did not get the name of her nurse and the name of the drug prescribed to her, she was not willing to ask for clarification or more information. Further, Meriam stressed the need to realize that even though she spoke English, it was not her first language, and she may not have understood every word:

> [The nurse] was not nice at all, even in her way of introducing herself, it was so fast, I did not grasp her name, she was expecting that I speak English and could listen and grasp what her name was from the first time. It was hard. Even her name, I could not recall. I did not want to ask, as I did not want to show her that I could not speak English really well . . . I wish also that the nurse realized that I was a foreign, and I speak another language, and was sick so she has to be patient with me. I was not in a situation that I was able to recall all the terms, terminology . . . When the doctor decided to transfer me to another hospital, I was worried about its address and I felt that I did not want to ask, so I decided to go there and I would ask them about the address. But no one asked me “who do you want us to contact for that?” or “do you have numbers of people to contact them”, nobody asked. I had a cell phone and my daughter had a cell phone and it was a dame, I did not want to tell her and planned on a time, but no one asked me about what I was going to do, I did not feel care

> from them. The second point is that I did not know the name of the other hospital, so they gave me an abbreviation for the name.

In these two stories, no explicit, clear, and unambiguous communication existed between the health care providers and Meriam. For Meriam, disengagement resulted from the nurse’s fast introduction, which reflected her lack of understanding of the needs of patients who had a different cultural background and who spoke a first language other than English. Meriam interpreted this attitude as uncaring; providers neither asked about her needs nor were they patient with her in addressing her unique language and cultural needs. Davidhizar and Giger (1998) emphasized that culture and communication are connected and that culture cannot be “transmitted and preserved” without clear communication (p. 21). Communication needs also to be a two-way mutual exchange in order to be effective and to lead to the desired outcomes, which includes patients' trust and satisfaction (Munoz & Luckmann, 2005; Srivastava, 2007). Looking at one side of Meriam's story, the nurse did not make an assessment of what Meriam needed. The nurse was not sensitive to Meriam's unique cultural needs; this could have been obtained through open communication. Because Meriam spoke another language, it was simply more challenging: medical terminology can cause difficulties in communication even if health care providers and patients speak the same language. Thus communication is even harder when patients speak different languages (Dawood, 2005) and have different cultural backgrounds, as patients may have different understandings and communication styles that make the engagement more complicated (Korac-Kakabadse, Kouzmin, Korac-Kakabadse, & Savery, 2001). In other words, patients and health care providers are not motivated to be engaged with each other when they speak different languages and have different cultural backgrounds.

Looking at the situation from another perspective, Meriam did not communicate her needs to the nurse. It may be that Meriam did not feel that the nurse was open to creating a positive space for engagement where Meriam could feel the degree of trust and openness required to converse and express her feelings. Further, it may be that Arab culture played a significant role in this scenario, as some Arabs see their health care providers as the sole decision makers, and when the nurse did not ask her or assess her needs, Meriam may not have been able to ask for what she needed. Instead, she waited for the nurse to ask, but regrettably, the nurse never did. This points to the patient's beliefs in her role in the nurse-patient relationship (Al-Shahri, 2002; Dawood, 2005; Jones, 2008; Srivastava, 2007). Srivastava (2007) indicated that patients sometimes find it difficult to express their needs, as they are afraid of being judged in a powerful and hierarchical health care system. In some cultures, asking for help is not a preferred practice, as patients think health care providers may look at them as incapable people. They, instead, wait for someone to offer help (Dastjerdi et al., 2012).

Meriam further illustrated the point of the "asking-education." In other words, Arabs should learn how to ask for their rights in the context of being informed, educated, and aware of their choices. Meriam gave examples of the need to ask for interpreters when English is a problem when communicating, especially when a signature is needed. She also urged Arab immigrant women whose English is not good to ask their neighbors or friends to accompany them when visiting the ED. By asking, patients would know, with certainty, what resources are available for them and how to access these. Meriam articulated this point:

> One important thing that we have to learn is how to ask for an interpreter and how to refuse to sign any paper or take anything, unless somebody explains it to us clearly, especially when it involves surgery or admission. I think it is really important, if you are new here and your English language skills are not good enough and you are on your way to the ED, to have somebody who speaks the language fluently, [like] a friend or a neighbor… Indeed, we did not ask. We cannot say whether that they have or don't have [a thing if we do not ask] . . . If I, the patient, ask, there is maybe an accurate response available to my questions. But we did not really ask.

Another integral point that Meriam raised and noted in the literature (Srivastava, 2007) concerned the inability of the woman to concentrate at the moment of sickness and in a place of unfamiliarity. Meriam said "The problem is the limitation in language proficiency . . . even if someone speaks English fluently, she might have difficulty with the medical terms because of her tiredness and sickness. She won't be able to concentrate on what is happening." Nurses should be aware that when patients visit EDs, they are weak, sick and emotionally unstable. When this is a place they are visiting for the first time in their life in a new country, their embodied experience is further disrupted and their anxiety level increased. Meriam's story is not different then what has been found in the literature related to other immigrants, insofar as they too have had challenges with providers in care because of language barriers. Dastjerdi and colleagues (2012) in their study examined the experiences of

Iranian immigrants when accessing the Canadian health care system. Their study included 11 Iranian immigrant women who were struggling because of their limited English skills and were not able to express their needs or communicate effectively.

Participants in this study unanimously asserted the need for interpreter services and for Arabic brochures and other health educational materials to be in Arabic in EDs and in any other hospital settings. Interpreter services are very important when patients cannot speak English, and the lack of these services is a form of the system’s discrimination against immigrant women (O'Mahony & Donnelly, 2007). Interpreters should not only interpret the concrete meaning of words spoken but also the nonverbal messages and any gesture or movement that may influence meaning. Health care providers, at the same time, should look and interact with patients. Where this occurs, nurses and other health care providers are able to make an accurate assessment of patients' specific cultural and individualized needs (Brach & Fraser, 2000; Davidhizar & Giger, 1998; Hammoud et al., 2005; Srivastava, 2007) and to provide congruent embodied care. Participants in Dastjerdi and colleagues (2012) indicated they preferred not to ask for interpreters, as their doctors ignored the participants’ presence and interacted mostly with their interpreters. These participants described this behavior as discriminatory and as a source of marginalization, which dehumanized their experiences. Hitchcock, Schubert, and Thomas (2010) further contended that interpreters should have “cultural sensitivity, understand how to impart knowledge, and understand how to be a client advocate to represent the client's needs to the nurse” (p. 242), which is called “cultural interpretation” (Srivastava, 2007, p. 38). Female interpreters are preferred by many Arab immigrant women, especially when discussing sensitive issues (Hammoud et al., 2005). Participants in this study indicated that they did not know if interpreter services were available in EDs. However, they did not ask about it. Doaa mentioned that she had been offered an interpreter who was an Arabic doctor working in the ED, but he was a man, and she did not feel comfortable expressing her feelings in front of him as a result of Arab culture. “If I did not understand something, I asked them to repeat it because there were no interpreters. There was actually one doctor who was Arabic, but he was male. So I just did not want him to know anything about me. You know our culture.”

Patient language comprehension and the need for an interpreter should be assessed by health care providers (Munoz & Luckmann, 2005; Srivastava, 2007). Meriam understood the importance of assessing the need for interpreters: “I think that if any person asked for a health insurance, they should from the beginning assess their language skills abilities, and the extent of her understanding to the Western culture, and the waiting [time].” Iman recalled that her health care providers did not assess her language skills and did not care if she understood what had been said. Assessment should be done for health literacy reasons in every encounter with patients to determine patients with low health literacy in order to help them throughout their illness period (Lambert & Keogh, 2014b). Health literacy “is the extent to which people can access, process, understand, use and communicate health-related information (oral, print and numerical) skills and services” (Lambert & Keogh, 2014a, p. 31), which enables them to make health-related decisions (Eadie, 2014). Authors argued that health literacy is very important for effective communication. Iman said: “They spoke at their normal pace, as if they were talking to a native speaker. [Silence.] I did not really feel that they cared if I could not understand or, I mean, they did not ask me if I understood what they were saying.” Doaa echoed what Iman shared by saying “I had a problem with the language when they talked, they were really fast. They assumed you speak English, without even asking.”

Besides verbal communication, nonverbal communication is crucial when dealing with patients, especially those who have different cultural backgrounds. I unravel the importance of nonverbal communication in the next section, by sharing Arab immigrant women's stories that revealed how disengagement resulted when health care providers did not understand or pay attention to their nonverbal communication.

Disengagement and Cultural Nonverbal Miscommunication

Nonverbal as well as verbal communication plays an integral role in the relationship between patients (Arab immigrant women) and their health care providers (Davidhizar & Giger, 1998; Kacperek, 1997; Munoz & Luckmann, 2005; Srivastava, 2007). Touch, smile, and gaze are needed from the initial moments of care to promote the engagement process. Goldberg (2004) indicated that when health care providers avoid eye contact with their patients, the chance for disengagement to take place is increased. Merleau-Ponty (1964) emphasized the importance of looking as a part of body movement to interact and engage with a thing or a body. When health care providers do not look at Arab immigrant women, some of whom value eye contact, then the “power of looking” that enhances their relationship and comfort within a space of unfamiliarity is blocked. Merleau-Ponty stated:

> I have only to see something to know how to reach it and deal with it, even if I do not know how this happens in the nervous machine. My mobile body makes a difference in the visible world … We see only what we look at. What would vision be without eye movement? (p.162).

Diversity within Arab culture is a crucial point for health care providers in EDs to consider when assessing Arab immigrant women. Even though eye contact for some Arab women is avoided, especially when they deal with men (Fields, 2007; Hammoud et al., 2005; McKinnes, 1999), for other Arab women, eye contact is important and produces a feeling of being welcomed when dealing with health care providers. Thus, health care providers who work in EDs should build the skills that enable them to quickly and accurately assess their patient's needs, even in a busy and overloaded work environment (Wolf & Delao, 2013). A quick and accurate assessment could be done not only by paying attention to the patients' nonverbal communication but also by directly asking them about their cultural preferences while taking their vital signs, making the physical assessment one that includes cultural information. For example, the nurse, while taking blood pressure, could observe the patient's reactions when the nurse looks directly to her eye. If the woman avoids eye contact, the nurse should know that this woman may not prefer direct eye contact. To confirm this observation, the nurse could ask the woman in a respectful way whether or not she is comfortable with direct eye contact. By asking patients' directly about their needs and preferences, the assessment could go beyond the woman's body to include her culture, showing respect for this woman's culture and promoting a shame-free health environment. Further, the nurse is saving time as she assesses simultaneously the physical and cultural aspects of care.

Facial expression can enhance or block the engagement process from the first moment that health care providers meet with Arab immigrant women. For example, Iman, with profound sadness and anger, revealed how she was insulted and felt withdrawn because her doctor made facial expressions that are interpreted in Arab culture in a way that suggests Iman might not be telling the truth:

> Then a doctor came. She was not Canadian; she looked Asian. At first, she was nice. She took some information and told me that she would wait for the results. After she left, I went to the washroom and vomited. When she came back, I told her, so she was "Oh, I want to see it" and she walked to the garbage can. I told her that I had gone to the washroom, so she started to make some facial expressions. I did not know what she meant. Maybe she thought that I was lying to her or something, but she started to interact with me differently, like I was a liar. I was about to tell her "do not think that I would come here and wait for 12 hours or so if I was not really sick, I do not need a sick leave note, all what I need are respect and treatment," but I did not say anything because I did not want to get angry while pregnant.

The doctor, with her facial expression, likely did not mean what Iman thought. This nonverbal expression may have had a different meaning in Asian culture than in Arab culture. If this provider had more knowledge about Arab culture and the skills to provide competent cultural care, she may not have behaved in this way. She would be cautious when making any gesture or nonverbal communication, as it might be understood differently by Arab immigrant woman, as in the above situation. Misunderstanding may have taken place on both sides; the physician may not have meant to insult Iman and may have wanted to communicate something else to Iman with this specific facial expression. Meanwhile, Iman did not understand what the physician wanted to communicate and did not ask. Davis (2000) developed an effective module that can be used by registered nurses in EDs to avoid such misunderstanding and to help these health care providers nonverbally communicate more efficiently with their non-English speaking patients. The module consists of signs, symbols, diagrams, and drawing designs for symptoms that are seen commonly in the EDs. Patients are asked to point to signs or symbols that reflect their feelings; their pain intensity, duration, and characteristics; and/or any other symptoms they have. Nurses evaluated the module as effective and indicated that it would help them when dealing with non-English speaking patients.

For nurses to be able to provide culturally congruent care to patients from different cultural backgrounds, they need to understand the meaning of cultural communication and what it entails (Munoz & Luckmann, 2005). Nurses thus require education to bring awareness to patients' cultural values, beliefs, and practices, as well as their own values, prejudices, and biases in order to be able to control them when dealing with patients. Failure to provide culturally congruent care to patients in EDs may lead to repeated visits, unnecessary treatment and/or diagnostic procedures, decreased levels of patients’ understandings, and low satisfaction levels (Jones, 2008). Knowledge about Arab culture is key to communication and to providing culturally congruent care that enriches the nurse-Arab immigrant woman relationship.

However, this general knowledge should not be the basis to deal with all women from Arab culture. Assessments need to be done with each woman to reveal her individual values, beliefs, and world view. Nurses should also have the skills to use cultural assessment tools to gather data about Arabic culture. Cultural assessment is "a systematic appraisal of individuals, groups, and communities relating to cultural beliefs, values, and practices." With this assessment, health care providers are able to know the unique needs of each individual within a culture and to provide culturally congruent care (Erickson-Owens, Good, & Zdenek, 1998, p. 22). Stulik (1985) developed a cultural assessment tool especially for Arab-American patients. Even though culture evolves, and it has been a very long time since this cultural assessment tool was established, its component is still relevant to the Arab population, and it is the only assessment tool I found that is designed specifically for Arabs. This tool includes cultural lifestyles and patterns; values, norms, and expressions of an individual or group; cultural taboos and myths; worldview and ethnocentric tendencies; cultural diversities, similarities, and variations; life caring rituals; folk and professional health-illness cultural system; caring behaviors and nursing care values, beliefs, and practice; and the aspect of cultural change. A desire and willingness to work effectively, to be sensitive, and to provide congruent cultural care to this minority of women helps nurses to communicate effectively and to build a positive space for engaging immigrant Arab women and increasing their positive health outcomes.

Disengagement and Cultural Gender Differences

Some women in Arab culture prefer not to be exposed to male health care providers (Gulam, 2003; Hammoud et al., 2005; Kulwicki et al., 2000; McKennis, 1999). Iman recalled that paramedics were not sensitive to her cultural needs even though they heard her talking with her husband about how she could not expose her arm in front of the male paramedic. Iman was frustrated when the female staff person did not offer to take her blood pressure and when the male staff member remained while Iman was trying to remove her jacket. Both providers were staring at Iman and her husband, waiting for her to let them continue with their procedure, and Iman interpreted this attitude as disrespectful to her culture. Iman's disengagement resulted when the health care providers did not have any reactions toward what Iman and her husband were saying and did not give Iman the needed space to remove her jacket comfortably. The health care providers, nevertheless, may not have wanted to interfere as Iman was not talking to them directly, and they may have considered their own attitude as respectful to the privacy of this couple. Iman told her story:

> In step one, there were two nurses, a woman and a man. The man was just standing there. The woman [who] was on the computer . . . asked the man to take my temperature and blood pressure. Here was the problem: I was wearing a sleeveless t-shirt under my coat. My husband was really upset. He asked me why I wore that shirt when I knew that the nurse or doctor could be a man. However, he just agreed to let me expose my arms to the male nurse because I was sick and there was no way to go back home and change my shirt . . . To be honest, [the staff] had no reaction at all. I was talking with my husband, and

> they heard us, but they did not say anything. The woman was staring at her screen and then looked at the man, who was standing waiting for me to remove my coat. They did not even ask if they could do anything. I was shocked that the man did not even move so I can remove my coat comfortably before he could take my blood pressure. It was really not good… The nurses in the triage did not respect my culture. They did not ask me what I wanted them to do, or at least, the woman nurse did not offer to take my blood pressure instead of the man.

Another story was shared, sadly, by Safa, who described how a staff member in the waiting area treated her differently and was rude when offering her a pad for her bleeding in front of men. In Arab culture, such a practice is often thought of as a woman's issue that should not be discussed in front of men (Kridli, 2002). The staff may not have known about this cultural difference. However, privacy is very important when dealing with patients, and patients' conditions should not be discussed in front of any other person (Olsen, Dixon, Grey, Deshefy-Longhi, & Demarest, 2005; Woogara, 2001). Safa described her experience with this particular staff member in the ED. She said:

> There was one who always came. I don't know who she was, a nurse or a security guard. She looked, followed up. If they were sleeping, she gave them a blanket and asked them if they needed a pillow. And when she passed by me, I told her that I was really tired and asked her to let me in, but she refused. She was not good when dealing with me. I told her that I was really tired, but she

> said "I will give you pads," in front of all the men in the waiting area. I was really ashamed that everybody there knew that I had bleeding.

In this scenario, the health care provider was not only insensitive to Safa's cultural needs by talking in front of others about a condition considered private in Arab culture, but she also breached one important aspect of all patient care (Back & Wikblad, 1998). For a health care provider to build a therapeutic relation with a patient from a different culture, the patient should clearly understand that her condition should not be discussed or disclosed to anyone other than those involved in the treatment (Munoz & Luckmann, 2005). When patients' privacy is breached, trust is lost and patients' autonomy and dignity are not respected (Oslen et al., 2005; Scott et al., 2003). However, Safa described that this hospital staff provider nevertheless dealt with patients in a caring way, offering them blankets and asking about their needs. Yet, the same provider did not seem kind when she passed by her. Lack of knowledge about Arab culture may contribute to this kind of treatment, as health care providers may not be willing to address the needs of Arabs and may regard them as a difficult group to deal with (Aboul-Enein & Aboul-Enein, 2010; Kirdli & Fakhouri, 2003). Difficult patients are defined as patients who do not follow nurses' instructions, ask too many questions, and are too demanding (Khalil, 2009; Michaelsen, 2012). This paramedic's attitude could be interpreted as discrimination, which is defined as the practice in which a person treats another person or a group differently (Merriam-Webster, 2014). This finding is similar to what participants in a study by Dastjerdi and colleagues (2012) shared: that some health care providers did not understand their cultural needs, did not show care to learn their needs, and discriminate against them. This practice leads to health care inequity and limits the care provider ability to provide culturally safe care. Thus, health care providers' awareness and knowledge should not be limited to Arab culture but should include cultural safety and its importance in health care settings. Cultural safety goes beyond cultural awareness, sensitivity, and competence. It concerns the understanding of issues on power differences and inequities within the Canadian health care system and how to address and eliminate such issues. The concept of cultural safety includes advocacy to disenfranchised groups by taking actions and steps to remove any constraints or oppression placed on them by others (ABNAC, CASN, & CNA, 2009).

Disengagement and Distrust

Trust between nurses and patients is vital in building a therapeutic relationship and should be established from the very first moment that a nurse and a patient meet (Dinc & Gastmans, 2012). Trust is “an attitude bound to time and space in which one relies with confidence on someone or something, and is a willingness to engage oneself in a relationship with an acceptance that vulnerability may arise” (Dinc & Gastmans, 2013, p. 501). When distrust takes place in a relationship, engagement is impossible and the ability to embody cultural care is restricted. A patient’s attitude and desire to be engaged with health care providers is also influenced by that person’s trust in the system as whole (Staudt et al., 2012). Meriam, in telling her story, shared her belief that if the system were not able to help those more critical than her, then it would not be able to help her. This negative attitude affected her experience in the ED and in her desire not only to be engaged with her caregivers but also to live in Canada. She stated:

> I felt that this place was not the right one; it would not help me, if those people were in a more severe pain, and no one could help them, how they could help me. The situation as a whole was so negative, so negative indeed . . . if I had to live here, believe me, it would be scary if I need to go to this hospital again. Now, when I started to feel a pain again, I pray to God not to go to this hospital again, maybe there is someone else is very sensitive to the extent that she would leave the study…but if I had a chronic disease, and from time to time I had to go to the hospital, so I don't think that I would continue my study here. I would not even think about immigration because I really suffered to be honest with you.

Trust is an important aspect of providing culturally competent and patient-centered care (Jones, 2012; Kim-Godwin, Alexander, Felton, Mackey, & Kasakoff, 2006; Warda, 2000). From the moment trust is violated, Arab immigrant women felt that their cultural needs were not met or respected. Iman in her experience felt that the staff were unprofessional, not honest, thus creating a space where engagement was diminished and trust destroyed. Iman's condition deteriorated as she spent three hours waiting while pregnant with nausea and vomiting. She told hospital staff that she was not feeling okay; one staff provider promised to tell the doctors and asked her to go and wait, without even asking her name. As this didn't occur for some time, Iman interpreted this as dishonesty because the paramedic couldn't tell the doctor about her without knowing her name. With anger and frustration, she described this moment as "shocking"; she could not believe that a health care worker could lie to a patient, and in telling her story she stressed that her culture was not respected:

> After about three hours waiting, I started to feel really bad from the nausea and vomiting. So, because there was a sign in the triage that said: "If you feel worse, please tell us", I told a nurse, and she said "Okay, I will let the doctor know," without even asking my name. I was shocked that she lied to me. She didn't know me, so how could she tell the doctor? I could not believe that a nurse would lie to a patient. It was a terrible feeling that I felt that time, and I was really angry. My husband tried to calm me down because he was afraid that the baby could be affected when I became angry. Do you know what does lying mean to me? They did not care about my needs and they did not respect my culture.

This chapter illuminated practices that nurses and other health care providers engaged in, perhaps unintentionally, with Arab immigrant women in EDs. The practices that constituted the experience of disengagement, as seen by Arab immigrant women, were shouting; lying; being tough, rude, not smiley, and impatient; not listening to, refusal to attending to, and not respecting their unique and cultural needs and/or their privacy; lack of self-introduction and/or disclosure; and not empathizing or paying attention to their emotional needs. These practices led to anger, frustration, pain, scariness, crying, uncertainty, shock, and terrible feeling to the extent that some did not want to continue to live in Canada. These feelings may be similar to what Canadians feel when interacting with such health care providers. However, Arab immigrant women's suffering was complicated by a different cultural background and a different language. In the following chapter, I attend to the theme "Suffering While Waiting" and the ways in which the women's narratives address the issue of the ED as a space and physical place that greatly influenced their ED experiences and implications for care.

Chapter Five

Suffering in Pain While Waiting

"The whole atmosphere was not comfortable, and you can smell the sickness with no fresh air… I was frustrated and felt more pain." *(Meriam, study participant)*

These words were shared by Meriam, a participant in the study, when she described the waiting area in the ED she visited in HRM. The crowded area—a space described as cold, unclean, smelly, with uncomfortable chairs—and the other waiting patients collectively had negative effects on Meriam's experience in the ED. Overall, she felt as if she was in a shelter not in a hospital, and she was frustrated because it was not what she imagined about the Canadian health care system. She continued her story:

> The waiting [area] was so miserable. The chairs were bad, and the place was so crowded, and I was not sure if that place was clean or not. Besides, the smell was not pleasant at all. There were also people who came from the street, I was not looking down at them, but [silence] I came into a place and it was supposed to be a "healthy" place, so it has to be clean. Maybe the cleaning was not bad but it was the misusage of it. Furthermore, the [comfortable] chairs were limited . . . the uncomfortable chairs were too many [silence]. The room was so cold, really really cold and people there were asking about sheets and covers, and others came with their blankets. You feel like you are in a shelter, in a bad place, not a hospital [laughter]. It was not at all what I expected about hospitals here, at all.

In this chapter, I illustrate how lived time and lived space as indicated by the lengthy waiting times and the ED's physical setting negatively influenced the experiences of the Arab immigrant women in the context of the study. The chapter concludes with suggestions generously shared by the women, as they offered alternatives to their current experiences, potential changes to better reflect their diverse cultural needs within the current provincial health care system.

The Endless Wait Time

Waiting in EDs is inevitable, as crises may come at any moment and patients who are severely ill are served first (Baraff, Bernstein, & Bradley, 1992; Gordon, Sheppard, & Anaf, 2010). The way a person feels can influence that individual's experience of time and of the world during a specific time. Conversely, restrictions placed by time can also affect the feelings of a person (Van Manen, 1997). In this study, being sick in an ED influenced how Arab immigrant women experienced and perceived time. Further, the long waiting period affected Arab immigrant women's physical, mental, and spiritual experiences. Derlet and Richards (2000) indicated that the delay of care provided, which may result from crowded EDs, leads to poor health outcomes and to patient dissatisfaction, as patients suffer when waiting for a long period of time. Bradley (2005) and Burely (2011) further stressed that patient safety is jeopardized as a result of the crowds and the lengthy waiting time. In such situations, health care providers are under pressure to make decisions quickly in order to speed the flow of the patients, and some patients may receive their treatments in hallways and in the waiting areas. Safa, a participant in the study, described how the waiting exacerbated her pain and bleeding, as she had to walk and use the washroom several times, which added to her dissatisfaction with the care provided. This dissatisfaction was reflected in her crying from her resulting pain while waiting. The waiting, in Safa's case, put her safety at risk as bleeding may lead to complications, such as iron deficiency anemia, which is a condition associated with shortness of breath, rapid heart rate, headache, and other symptoms. If anemia is severe, it may cause heart and lung problems (Schub, 2012). Without a follow-up, nobody would know if Safa had developed such complications or not. She reported:

> To be honest, I did not like the experience because of the very long waiting time. I had to wait a very long time to see the doctors. I did not like it at all. I waited really long . . . I had gone to emergency the same day in the morning, at seven in the morning. I waited really long, to the extent that I had a really severe bleeding and some tissues started to come out from my vagina, and I was crying all the time . . . I had to wait while in severe pain the whole time. Every then and now, I had to go to the washroom, and I had to change my clothes. The waiting experience was harder than the pain itself as it was a long period.

Similarly, Iman, another participant, emphasized that the waiting was the reason for her exhaustion, as her nausea and vomiting got really bad after three hours of waiting. Severe nausea and vomiting could also have threatened her life and the life of her fetus because of the dehydration and electrolyte imbalance that may result (Festin, 2014). She said:

> It was a tiring experience. I went to the emergency at 7 p.m. and left at 7 a.m. As I was pregnant with morning sickness, this increased my tiredness even

> more. It was the hardest part. Oh my God—I waited from seven in the evening till 4 in the morning. I really did not anticipate it to be awful like that. It was my first time pregnant and I had nausea and vomiting. After about three hours waiting, I started to feel really bad from the nausea and vomiting.

Because the EDs understaffing could be a cause of the crowds and the lengthy waiting time (Kai Tiaki Nursing New Zealand, 2010), Safa suggested increasing the number of volunteers and trainees who help with diagnosis and treatment in order to decrease the crowds and to speed the flow of patients. She reported:

> I asked a doctor a second time when I came with my husband. I asked him why there was such a long waiting time, and he told me there were not enough doctors in emergency. So patients had to wait because of the shortage. If there were enough doctors, rooms, and space, we would be able to finish really quickly. But now we waited until a doctor finished a case to be able to examine another . . . It would be better if they had more rooms and enough doctors. They could bring in trainees, PhD students, students who are applying for a PhD, or nurses (the ones who are at the universities). They could bring them to work in EDs as trainees, so there would be more workers in the ED and patients wouldn’t have to wait as long.

While an observant suggestion by Safa, it nevertheless requires the cooperation of policy makers to approve the restructuring and delegation of workload. Bradley (2005) urged nursing and other health care provider organizations to have emergency overcrowding as a main problem on their political agenda and to find strategies at the provincial level to decrease crowds and to maintain patient safety. A recent event in HRM showed that understaffing was part of a potential labour strike related to nursing, with a union request for mandated numbers of nursing staff for patient safety on all units. During this strike, many surgeries and care services would be postponed, in turn imposing more emotional and physical stress on the affected people (CBC News, 2014). While this particular strike was not only for emergency nurses, it shed light on the ongoing issue of an insufficient ratio of health care providers to patients across the health care system—although emergency poses particular challenges given its high acuity, large numbers, and demand for quick turn-around. Thus, collaboration and agreement should be settled between unions, health authorities, and the government to ensure patients' safety.

Frustration, impatience, and anxiety are common problems associated with the long wait in EDs (Cohen, Wilkin, Tannebaum, Plew, & Haley, 2012; Gordon et al., 2010; Wanzer, Booth-Butterfield & Gurber, 2004). Such problems should be handled by health care providers. Meriam made an important point about how the unfamiliarity with the typical waiting period could cause problems because long waiting aggravates pain and tension, especially for non-English speaking patients, as they do not know how to ask about their turn or about the system. Hence needs assessment and education for Arab immigrant women (and Arabs in general) about the waiting period in the EDs are imperative, as this education could decrease their tension or cause them to rethink their decision to visit EDs. Verbal education or the use of handouts are associated with patient satisfaction and supported by participants (Baraff et al., 2003; Stuart, Parker, & Rogers, 2003). Meriam suggested that a formal website or a place where information about ED waiting can be sought would be helpful, as it is lacking in the current system. Meriam stated:

> I think that if any person asked for a health insurance, they should from the beginning assess . . . the extent of her understanding to the Western culture, and the waiting. They should let her know that you have to wait for a long time, so you do not need to go back and forth and ask before they call you . . . There is no formal place says that: 'this is our system, our emergency here is not like a real emergency, we have an emergency that you could wait for 8 hours or 12 hours.' If we are not aware about this, I think, especially the ones who cannot speak English, they could cause a lot of problems because of the pain. They don't know the system, they do not know that because of the staff shortage, the emergency means inevitable waiting . . . When you know, the way would be easy to get other services. In other words, she may think to go to a family doctor better than waiting for a long time. In my understanding, emergency is a lifesaving but here it is not emergency indeed, unless it is a case that threaten the life.

The evidence suggests that the more that health care providers empathize with patients and give them the care needed, the more patients' anxieties are alleviated (Baraff et al., 1992; Cohen et al., 2012;, Gordon et al., 2009; Kihlgren et al., 2004; Nyden, Petersson, & Nystrom, 2003). Being empathic as a health care provider means having the ability to understand the feelings and thoughts of others and being sensitive to their needs (Kelley & Frinzi, 2011; Merriam-Webster, 2014). In the case of long waiting times, being empathic as a health care provider could be achieved by explaining the reason for the wait (Baraff et al., 1992; Young & Flower, 2001) or by rechecking vital signs (Cohen et al., 2012). Allowing family members to stay with patients also shows empathy and helps to decrease the anxiety associated with wait times (Baraff et al., 2003). Arab immigrant women may need more empathy and affection as they are not familiar with the Canadian health care system, which causes uncertainty. Uncertainty, especially in moments of sickness and weakness, leads to more anxiety and fear (Baraff et al., 1992; Nyden et al., 2003). However, such empathy could be challenging to provide given the busy environment in EDs, which in turn can lead to more anxiety and impatience with those who are ill (Lin, Hsu, & Chong, 2008). Meriam, in her story, emphasized the idea of care and empathy and revealed that her waiting could have been made more bearable with the presence of care and follow-up. She described how the long wait combined with the careless attitude of some health care providers contributed to more pain. She stated:

> Nobody asked about us and no nurse came to ask you about the pain and follow-up the pain each hour after doing the first assessment. This is what I know, there should be a follow-up. It should not be you assess and forgot about it for 8 hours . . . Maybe because it was crowded, but really I felt that it was not the thing I had imagined. According to what I know, and based on my background, the nurse has to do a lot for patients . . . The care would really help me bear the waiting and be patient. I did not feel the care I needed as a patient who had needs, so the pain was severe and the time was endless.

Patients' perception about time can have a worse effect on their psychology than the actual waiting time (Davis & Heineke, 1998). Informing patients about the reasons for their wait is a way to decrease their perception of the long wait time and make it bearable (Kihlgren et al., 2004; Stuart et al., 2003; Tran, Schutte, Muelleman, & Wadman, 2002). Distracting patients from thinking about the long wait by occupying their time is another solution that is found in the literature to change patients' perception of the wait time (Cohen et al., 2012; Tran et al., 2002). Nada indicated that having booklets or magazines in the waiting area could help patients with their long waiting: “in the waiting area, there were no brochures or booklets, so we could not entertain ourselves while waiting. I am not talking about education, but entertaining things, like magazines.” These magazines or any other posters should reflect the cultural diversity in the EDs (Stuart et al., 2003). For example, they could be offered in languages other than English, such as Arabic. Iman also suggested having the television turned on a comedy channel as a way to distract patients from pain: “There was also a thing . . . the TV was on a news channel that made me felt sicker. A simple thing that could be done with no cost is to put the TV on a candid camera or a comedy channel that distracts patients' from thinking about their pain.”

It is noteworthy to mention that the long waiting is not a problem for Arabs or Arab immigrant women only, as it is also a challenge for Canadians and other nationalities. However, the waiting may be harder for these participants as most used to visit hospitals where the maximum wait time was about 15 minutes. Hence, they may not have the patience to wait, and some of them may go several times to triage staff to ask for their turns. Most participants in the study mentioned in their stories that they went to ask for their turn many times. Meriam stated: “I did not feel that there was a follow-up or evaluation of pain. After almost three hours passed, my daughter and I went to ask about our turn, and for the second time they asked us to wait because there were so many cases." Safa also indicated that her husband asked about her turn many times: "[M]y husband asked them several times when my turn would be. They told him that they didn't know, you just have to wait. So they did not even know when exactly I would go." According to Aboul-Enein and Aboul-Enein (2010) and Kirdli and Fakhouri (2003), health care providers, because of how Arabs seem to be impatient, may regard them as difficult patients to deal with. Further, the way Arabs may act could influence the desire of health care providers to work with them (Marrone, 2008).

Another dimension of patient suffering in the ED was that, during their long wait in the lobby before entering the treatment rooms, participants in the study were forced to see other patients who also suffered while waiting. The next section reveals how the images of other patients' suffering stayed with the participants, who shared with sadness how seeing others in pain affected negatively their lived experiences in the EDs.

Suffering with Others While Waiting

Neither the effects of others' suffering on patient experiences in EDs nor the role of the physical environment influencing this were sufficiently documented in the current literature. To date, a few studies were found related to patients' attitudes toward other patients, in addition to patients' attitudes toward the physical environment and their impact on their experiences (Baraff et al., 1992; Britten and Shaw, 1994; Kihlgren et al., 2004; Lee et al., 2014; Nyden et al., 2003; Stuart et al., 2003; Watson, Marshall, and Fosbinder, 1999). In what follows, I discuss the effects of the space of the ED and how it was inhabited and lived experientially for the participants, in relation to themselves and to others during their hospital admission. The evidence suggests that a hospital admission is more challenging for those patients who have no earlier access to the health care system (Kihlgren et al., 2004). As a result, Arab immigrant women may have a harder time adapting to the setting and the environment, especially when the visit is their first to an ED in HRM.

Merleau-Ponty (1964) emphasized in his concept of interconnectedness that a person's body is connected and related to its surrounding environment and that humans are not passive but actively engaged with other events and/or humans. Thus, an in-depth understanding of an experience of a human being entails an understanding of how she/he relates to a space through interactions rather than passive perception (Thomas, 2005). In this study, how Arab immigrant women connected with other patients and how their feelings silently interacted with those patients affected these women's own experiences. For example, seeing patients receiving their treatments in hallways had negative impacts on the experiences of other patients and jeopardized the privacy of the patients (Kihlgren et al., 2004; Stuart et al., 2003). Privacy concerns the ability to keep patients' information from being heard or known by others, to maintain patients' bodies from being seen by others who are not a member in the treatment, and to provide a private space for patients during their physical exam and treatment period (Lin & Lin, 2010). Safa, a participant in the study, tearfully and tragically illuminated how she felt terrible, anxious, and began crying when she saw an old man receive his treatment in the corridor in the ED because of insufficient treatment rooms and, in her view, nobody caring about him. Her psychological pain when seeing other patients suffering had negative effects on her own physical pain, and she felt more pain, and her bleeding got worse. She stated:

> In the evening, I was really in severe pain and I was crying, crying all the time. I saw all the people there, and I really felt anxious. I felt more pain because of that. It increased my psychological pain, which in turn increased my physical pain. I also remember [that] on the same day I was there, there were many patients on beds in the corridors because there were not enough rooms. Inside, there were not enough rooms. Some of the patients were really old and all were in the corridor on their beds, getting intravenous fluids. The reason was because there were no rooms . . . When I saw them, I was really touched. I mean, this was a hospital, they came to rest. Why were they in the corridor? It would be better to sit at home instead of a corridor. They were in the corridor and nobody cared about them. There was a person I looked at all the time in the corridor, and nobody came to see him. There was no nurse, nothing.

Safa's words showed that she silently connected with the surrounding patients, who negatively influenced her bodily experience. Seeing other patients' suffering and/or noise from other patients could be sources of distress for some patients. Noise could result from patients who are in pain, who are drunk or are drug users, or from their relatives (Baraff et al., 1992; Britten and Shaw, 1994). What Safa said was echoed in other participants' stories. Meriam, with deep sorrow and pain, narrated how seeing other patients in pain increased her own pain, fear, anxiety, and frustration, which made her experience “horrible.” She thought that if the system could not help those sicker than her, then it would not be able to help her. Even though she was emotionally connected with them, she needed something to distract her attention in order to feel better. What Meriam shared about the effect of seeing other patients suffering is emphasized in a study by Kihlgren and colleagues (2004). They examined the experiences of older patients in the EDs in Sweden, where patients described how unpleasant their waiting was when seeing other patients suffering while waiting or moving in and out of their beds, surrounded by their anxious family members. Meriam stated:

> I remember there was an old woman, who was vomiting, and crying in that day, and she was old and her accompany was treating her in a bad way despite of her old age . . . Imagine I had to bear that scene for 8 hours, can you imagine? I had to see all this in front of me. It was not a waiting room, it was a tiring room. I get so tired from all I had seen there [silence], besides my pain, I was waiting for my turn, there were cases which were more tired than me just like [that] old woman. I think her pain was more than mine. I had a pain, but she had more pain. Seeing someone who has pain is so painful, and makes you feel tired, and increases your pain, frustration, and fear. I felt that this place was not the right one; it would not help me. If those people were in a more severe pain, and no one could help them, how could they help me? . . . To wait in front of people who are suffering. It was really painful and horrible. The situation as a whole was so negative, so negative indeed . . . I felt that all people around me were all sick in severe pain and that increased my own pain.

> Even though I felt sympathize with them, I felt more pain; because I did not see a thing that distract me from the feelings of fear and sickness.

These silent connections with patients started in the waiting area and continued with Arab immigrant women inside their treatment rooms when they had to share these rooms with other patients. Nada, with profound sadness, remembered how the man beside her in the room, because of his smell, influenced negatively her experience in the ED and influenced how she could not tolerate the space and left the room. She said: “There was, in the same room on the opposite side, a . . . man. He was not clean and had a very strong odor. They put him near to me and they put a curtain between us, but his odor was very strong to the extent that I had to get out [of the room].”

The aforementioned stories are all examples of how sounds, smells, and images invaded the private space of the women in the study. These participants' silent connections that influenced their lived experiences in EDs were not only with the people surrounding them but also with the emergency environment as a whole. In the next section, participants shared stories about how the surrounding physical environment negatively affected their experiences.

Space of Pain and Suffering: The ED

The surrounding space in the EDs' waiting areas contributed to participants' suffering and pain, which negatively affected their experiences. Meriam, a participant in the study, waited for eight hours in the lobby with no food or drink, which made her experience in the ED more painful. She was afraid that she could lose her turn if she left to get food: “I was hungry and thirsty, but I was afraid to leave to get something to eat or drink. I waited for eight hours; it was not logical that we would not want to eat or go out.” Bright lights and white walls can also negatively affect patients' experiences in the waiting area (Kihlgren et al., 2004). Meriam suggested that: “The waiting room has to be a quiet place and has a dim comfortable lights,” and she further expressed how the lack of fresh air increased her pain, as her emotions affected her physical bodily experience: “The whole atmosphere was not comfortable, and you can smell the sickness with no fresh air [laughter], I was frustrated and felt more pain.” The smelly place and poor ventilation in EDs were also issues discussed by Britten and Shaw (1994) as having negative impacts on their participants. However, no suggestions were given in this study to address the issue.

Another physiological need that participants unanimously emphasized was the need for comfortable chairs to sit or lie on. They all indicated that the number of comfortable chairs was limited and that their suffering increased with the long wait while sitting on uncomfortable chairs. Meriam said: “limited [chairs] were comfortable; the uncomfortable chairs were too many.” Likewise, Safa in her story underscored the uncomfortable chairs as a source for her suffering and suggested that more comfortable chairs be brought to the waiting area: “In the waiting area, they could bring in more chairs and good chairs for patients to rest. The chairs were really uncomfortable. There were a few comfortable chairs, but the rest were really uncomfortable.” Nyden and colleagues (2003) warned that patient safety is also placed at risk when health care providers in the EDs are having trouble attending to patients' basic needs, such as eating and/or comfort. The research further indicates that the physical environment in EDs has a significant impact on the experiences of participants and their health outcomes (Baraff, et al., 1992; Britten & Shaw, 1994; Kihlgren et al., 2004; Lee et al., 2014; Watson, Marshall, and Fosbinder, 1999) and that these space issues should be addressed to maintain patient safety and comfort while waiting. The ED seems to be a toxic environment when compared to the words of Jean Watson on her beautiful piece on “the Zen of bed making,” particularly in how she thinks about re-imagining our practice and envisioning the bed as something sacred. Thus Watson (1987) stated: “The bed, . . . or nursing art stands alone in this example as a single statement, symbolizing beauty, simplicity, elegance, wholeness; it is an invitation to comfort, safety, privacy, rest, recovery and a place for healing to occur” (p. 238).

Suffering in a Mixed-Gender Space

The suffering of Arab immigrant women in the waiting areas in EDs was complicated by having women and men waiting in the same area, which was not the usual setting in most of the participants' home countries. Iman, one of the study participants, brought an important cultural point of view to the discussion of the physical environment when she told her story of the comfortable chairs in the waiting area, in which she mentioned that even though the comfortable chair was empty while she was waiting, she was not able to lie on it as she was ashamed to lie in front of men as a result of her cultural background. She said:

> I was sitting in a chair that was not comfortable. There was a sofa, one big sofa. So my husband asked me later on to go to have a nap there, after all the people left and it was empty. But I could not, I was really shy to lie down in front of men, to be honest. You know, we never do that in our culture. I was

> ashamed and my husband told me that my health was the most important, but I refused. I was really shy. So I waited in the uncomfortable chair, for long time.

Iman's words reflect a mixture of Islamic and cultural issues when Arab immigrant women access health care systems in Western World. Most Arab women cannot be exposed in front of men or have parts of their body outlined with tight clothes (Gulam, 2003; McKinnes, 1999). When Arab immigrant women lie down, there is a high chance that their bodies will be shaped and/or exposed. This way of thinking forced Iman to sit while suffering in the uncomfortable chair. In the Holy Qura'an, God, however, stresses that people should not do things that could cause harm to themselves (Suraat AlBaqarah; part 2, verse 195). Although Islam excuses patients from following such rules to prevent further harm, Iman was shy as she used to live in a country that considered lying in front of men as a strange act, even during moments of sickness.

The mixed-gender waiting area was also a problem for most other participants. In most Arab countries, waiting areas and wards in hospitals are separate for different genders (Al-Shahri, 2002). The literature proposed no suggestions or ideas to solve the mixed-gender waiting area problem in Western hospitals. Participants in the study, however, had a few suggestions with regard to separating men and women in the waiting areas of EDs, and they stressed that this could make their experiences better by giving them the feeling that their culture is respected and their individual needs met. Doaa, a study participant, suggested that a curtain to separate men and women would be beneficial and respectful: “In the waiting area, I prefer a place for women, for example, a curtain that separates men and women so that I could at least lie down and relax." A sign that indicated that 'this place is just for women' could be placed in order to prevent men from unintentionally pulling the curtains. Meriam had a similar suggestion with a partition or a hidden place with some chairs as an alternative, if having a separate room was a problem. Having a separate space could have made Meriam's time in the ED more relaxed—as she would have been able to lie down and remove her head cover. She also described how the chairs were arranged uncomfortably where she was, placing her back to others, which is culturally uncomfortable. Stuart and colleagues (2003) suggested that chairs could be arranged in a way where family members can talk comfortably. Meriam said:

> For example, in our culture, we cannot sit in a place with our back to other people or lay on the sofa there. For me, it was not comfortable at all. It was not the right thing to do. For me, I was not used to do it. I came from a culture where women have their own place, where they can relax, remove their head covers, lay down. But not in front of others [men]. So, you know that this culture prefers a private place, you could put some chairs in a place that is hidden, where they can relax. The scene was not comfortable at all … Not necessarily a room. Just a partition, even a small one that covers you when you sit. Something that makes you relax while waiting.

The mixed-gender place and the physical setting of the ED were not the only problems that Arab immigrant women faced while waiting; finding a clean and a quiet place to pray was another issue for them, which is discussed in what follows, as seen by these women.

Cleanliness, Praying, and Physical Environment in EDs

Cleanliness and the misuse of the environment were also issues discussed by Arab immigrant women, issues that influenced their lived experiences in EDs. The level of cleanliness of washrooms in EDs was reported by Britten and Shaw (1994). Iman, a participant in our study also complained of unclean washrooms: “I also used the washroom many times, you know, when a woman becomes pregnant. It was not good at all.” Rogaiah similarly mentioned how bad the cleaning was in the washrooms and pointed out the need for their voices to be heard by making complaints. She stated: “There was a problem with the washroom, though. I had to clean it before and after. I was not comfortable. It was not clean. We have to make complaints about the washroom.”

By talking about cleanliness in the emergency environment, an integral issue about a prayer space and washrooms could be discussed. Finding a quiet and a guaranteed clean place to pray can be a challenge for Muslim Arab immigrant women. Further, finding a washroom with a jug or faucets next to the toilet is another challenge, as Muslims prefer to wash with running water after toileting (Gulam, 2003; Ott, Al-Khadhuri, & Al-Junaibi, 2003). Although all participants either went in non-praying times or were excused from prayers because of bleeding, the place was not prepared for praying, as illustrated by Meriam, who indicated that the rooms and washrooms were not specially designed to help Muslims wash before praying and that the space was not wide enough to pray with the existing crowds, in addition to the cleanliness issue. She further explained that even though there was a prayer or a quiet room for meditation, there was no guidance unless a patient asked. She said:

> Even though there was a place, I was unable to pray, as I had bleeding . . . If I was able to pray physically, the place is not prepared for praying . . . There was no space to put my prayer carpet. Even though I could know the praying direction, it was difficult for me to pray in front of them, because they would ask you why and what. Nobody directed me to a prayer place . . . We cannot say whether that they have or don't have a prayer place. For example, at the university, we did not know that there was a prayer place, but they have a quiet room at the Killam Library and another room at the Research Center. They are not mosques but for anybody. They were divided for meditation . . . The washrooms were not prepared for the special washing for prayer; they were really small. Also, all of the patients were having . . . problems so it was really difficult for me to pray and to be sure that I was clean to pray.

This chapter revealed how connectedness in EDs between Arab immigrant women and the surrounding environment and/or other patients and providers significantly influenced their overall health care experiences. Their ED experience combined in this single event some of the most difficult issues for Arab immigrant women: waiting for a long period of time as a result of understaffing and room unavailability in a mixed-gender place that was unclean, smelly, cold, uncomfortable, with nothing to eat or drink, and with nothing to distract them other than a crowded space with very ill patients being treated in the corridor. The lack of follow-up and empathy from health care providers, along with participants' own lack of knowledge about the wait time increased their challenge. They described their emergency visits as painful, exhausting, horrible, terrifying, and frustrating, which is similar to how other nationalities were influenced by wait times and by the physical space of EDs. The chapter also reflected how Arab culture with regard to the physical environment and space played an important role in their dissatisfaction as patients. In other words, their lived experiences in the ED in HRM were more challenging as they had a different cultural background in addition to being new to the system. The chapter therefore proposed suggestions to give health care providers and potential institutional policy makers the opportunity to rethink their policy and practice and to advocate for diversity within their institutions. In the following chapter, I discuss the theme "Unfamiliarity with the Canadian health care system" based on Arab immigrant women's narratives and how their particular ED experience contributed to their anxiety and fear, as it differed significantly from what they typically accessed in their home countries.

Chapter Six

I Am Lost! Help Me Please!

The scary thing was I did not know anything about the EDs here. It was about one in the morning, and I was really scared. It was my first experience in a place that I was not familiar with—the environment, their way. I did not know where to go and what to do. (Doaa, study participant)

Unfamiliarity with the Canadian health care system and with the physical settings of EDs was a challenge reported by all the participants, regardless of their length of stay in Canada, their work backgrounds, or their nationalities. Language and communication barriers, along with cultural differences, added more challenges to the system's unfamiliarity. This chapter attends to the theme of unfamiliarity, the sense of being lost within the space of the ED, and the effect of this on participants in the study. This aspect of unfamiliarity in turn influenced the entirety of experiences for the Arab immigrant women who participated in the study and visited EDs in HRM for the first time.

Unfamiliarity with the Canadian Health Care System

Adapting to the unfamiliar. Adaptation to a new health care system was a necessity for the participants in the study, and the ways in which they previously accessed health care systems in their home countries needed to be re-structured and re-imagined to align with differences within the two systems. The current evidence supports the participants' experiences, suggesting that adaptation between immigrants is often variable and dependent on several factors, including the extent to which their home and host countries differed in cultural and social contexts, personal characteristics and communication styles of immigrants, availability of supports and resources, as well as life and work balance (Choi, 2009; Guruge, Hunter, Barker, McNally, & Magalhaes, 2009). Such factors may negatively affect people's ability to adapt to their new and unfamiliar life. When confronted with a new environment, people search for culturally familiar activities and places to feel safe and comfortable, to reduce their anxieties, and to better adapt to the unfamiliar life. When they cannot find the familiar space and cannot adapt to the new life, homesickness may result (Fallon, 2005; Son & Kim, 2006). In a study by Son and Kim (2006), one of the feelings that Korean immigrants underwent while away from home was homesickness when they saw a thing that evoked their memories and reminded them of their past. Some have mixed feelings of pleasure as they saw a familiar thing and sadness as they were away from their home. They further described how they were attached to culturally familiar things, such as Korean songs and food. Being unfamiliar with the health care system may have an amplifying effect, leading to more anxiety, sadness, hopelessness, fear, confusion, and tension. Guruge and colleagues (2009) indicated that being unfamiliar with the health care system prevented the female participants in their study from accessing the Canadian health care system and from using preventive care and health promotion services (Guruge et al., 2009). Thus, enhancing a sense of familiarity within the health care system may improve their access and consequently their quality of life (Son & Kim, 2006).

Not dissimilar from the aforementioned evidence, participant Iman in one of her narratives described how her lack of knowledge and unfamiliarity with the Canadian health care system, along with a lack of educational resources, challenged her and affected her experience in the ED, where she ultimately got lost. Being lost can be a frightening experience, even within a confined space, as it suggests an inability to find one's way; there is a sense of unknowing and the possibility of not being found. Iman further acknowledged her concerns when she stated:

> Another challenge was the system itself, you know it was a new system, and we did not know anything about it. We needed time to figure it out, to know where to go and what to do. But at first, we were lost, especially that there was no orientation or education to understand the differences [between our health care system and the Canadian system].

As indicated by the powerful words of Iman, adapting to or feeling alienated from a new environment can be profoundly challenging. When adaptation does not occur, often due to lack of knowledge and/or unfamiliarity with an environment, hesitant or avoidant behavior in accessing the health care system may result, leading to poor health outcomes. In a feminist study by O'Mahony and Donnelly (2010) describing unfamiliarity with mental health services in Canada, immigrant women felt distrust and fear in accessing the system. As a result, O'Mahony and Donnelly (2010) emphasized that current practices within the Canadian health care system must be challenged to meet the needs of marginalized immigrant women.

Not unlike the findings from O'Mahony and Donnelly's study (2010), Meriam's powerful narrative described how her unfamiliarity with the family doctor's role and her lack of familiarity with the Canadian health care system forced her to suffer from pain for two days before deciding to go to the ED. In her storied account of her experience, she emphasized that if she knew about the family doctor's role, she would have visited a family doctor, likely in a clinic setting or office, instead of initially treating herself before going to the ED and waiting for hours to get treatment.

In Saudi Arabia, the ‘family doctor’ concept—in itself and as a main entry to the health system—does not exist. The health care system in Saudi Arabia consists of public and private sectors. In the public system, primary health care centers and emergency departments are the entry for non-urgent and urgent cases respectively. Referrals can be made with a waiting period that varies depending on patients' conditions and the waiting lists. In the private system, however, patients have the power to self-refer to specialists and the waiting periods are shorter than those of the public system. Meriam described her experience and the many painful days she endured in not knowing the health care culture within Canada:

> We are not familiar with the culture of dealing with the family doctor in the Middle East, which has a really great impact. I was in severe pain. I tried to undergo the pain and took painkiller in my home . . . . If I knew about the family doctor, I would go in these two days I spent at home suffering from pain and waiting for the pain to decrease, instead of going to the emergency. So the family doctor would direct me where to go.

What Meriam described in her experience above is similar to the findings of a study by Choi (2013) concerning the experiences of new Korean immigrants in the US with the US HCS. Choi (2013) explained how new Korean immigrants preferred to wait and bear the pain, using self-diagnosis and self-treatment as methods for coping. Some, however, went to EDs after suffering at home. In this study, the differences between the Korean and US health care systems were reported to be the biggest problem they encountered after immigration, a problem that prevented some of them from seeking medical advice. Another study by Ngwakongnwi, Hemmelgarn, Musto, Quan, and King-Shier (2012) examined the experiences of French-speaking immigrants in Calgary hospitals and found that lack of knowledge about the health care system forced immigrants to limit their access or visit EDs for non-urgent conditions.

Public versus private health care systems. One of the major differences reported by participants, and one that confused them significantly, was the unavailability of private hospitals in Canada. Iman had different expectations and explained how shocking and frustrated she was when she first knew that there was no private health care system in Canada. She further compared what she used to access in her home country with the system in Canada. She also gave her point of view, based on her past lived experience, regarding the private health care system. This point of view, along with the waiting period she used to wait in EDs in her home country, resulted in her decision to visit the ED in HRM, where she experienced a long wait. Further, because of her unfamiliarity with the system, she did not know the role of the family doctor, and she emphasized the importance of educational sessions about this role. From what she described, Iman misconstrued the role of the "walk-in" clinics where she could go without an appointment with the role of the family doctor, where an appointment was required. She stated:

> I think I could have gone to my family doctor instead of wasting my time at the emergency. I did not know that I could go anytime, even if I did not have an appointment. In my country, if I do not have an appointment, I do not have to

> go the emergency but I can go to a specialist. In my case, [I can go to] an obstetrician, or [to] the emergency, so there should be an educational session about this. We had no idea about the roles of family doctors and when to visit them when we first came to Canada. I was shocked when I knew that there is no private hospitals here. There [my home country], I can go wherever I want, pay, and be treated at once. No waiting, nothing like that . . . I was frustrated. I mean, public system to me means waiting up to one hour before seeing my doctor in clinics, not the emergency. [Laughter]. It [public system] means that I would not be able to go to any specialist without referrals and sometimes appointments and referrals could take up to five or six months. So, if there is no private hospitals in my home country, I would definitely go to the emergency. That is why I went to the emergency here. I thought the wait would be like 15 minutes.

In two phenomenological studies (Guruge et al., 2010; Lee et al., 2014), similar findings about the unfamiliarity with different health care systems were reported by seven Portuguese immigrant women and fifteen Chinese immigrant women respectively, who indicated that a major problem for them when accessing the Canadian health care system in Toronto was the difference between the Canadian system and what they used to access in their home countries. They gave an example about the need for referrals from family doctors to specialists, which was not the case in China or Brazil. In their home countries, private health care systems were available at any time, and they could refer themselves to get any treatment they wanted. Dastjerdi and colleagues (2012) made a similar point about referrals, describing the power that Iranians have in their home countries to self-refer and how this difference negatively affected their patient experiences. In Saudi Arabian hospitals, for example, the situation was similar to what these authors explained, which in turn may contribute to these Arab immigrant women's confusion and hesitancy to access the Canadian health care system, including the ED.

Similar to the findings above, the differences between health care systems in Canada and in participants' countries of origin were also discussed in the context of the research during a focus group setting. The participants unanimously concurred that differences between health care systems could confuse them and ultimately make their experiences more challenging. For example, Meriam, in the context of the focus group, discussed differences in the two systems' priorities and how such differences made one of the other participants (Safa’s) experience frustrating, and upsetting. She said:

> If a patient’s background is about a different health care system, she would be confused when access this new system. The system in my country has, for example, bleeding as an urgent case. [Patients with bleeding] would be looked after immediately, whereas leg pain is not as urgent and such cases can wait or go to the clinic. Safa, here, with bleeding, waited for eight hours or so. That is why she was upset and not satisfied with the care here.

The experiences of Arab immigrant women worsened without information readily available to help them familiarize themselves with the system. In the next section, Arab immigrant women shared their feelings of frustration, anxiety, stress, fear, and anger when they could not get the information needed.

Unfamiliarity, uncertainty, and vulnerability. Because of their lack of knowledge about the system and the limited information available, participants described the US HCS as complicated and difficult to comprehend (Choi, 2013). Another study by Dastjerdi and colleagues (2012) about the experiences of new Iranian immigrants with the Canadian health care system illustrated that Iranians "felt disconnected from their familiar world, things did not make sense to them at first", and they felt isolated (p. 5). Participants in the study felt fear, hopelessness, and helplessness because of their lack of knowledge. Not dissimilar from the findings of Dastjerdi and colleagues (2012), Meriam described the Canadian health care system as "vague" and as a system that did not make sense to her compared to the Saudi health care system because she did not know how to access the Canadian System, did not know whom to ask nor where to go. She reported:

> I did not know what would happen, such as when I would meet the doctor, what he or she would give. I did not know the system here. For me, the system was vague. In other words, in Saudi Arabia, I know the system, and know whom I talk to, If I need to talk [to somebody], but here I did not know anything.

Lack of knowledge about the new health care system contributes to feelings of insecurity and vulnerability among immigrant women in Canada due to their inability to seek appropriate care (O'Mahony & Donnelly, 2010). Jiwani (2001) contended that unfamiliarity is one of the major obstacles to accessing the health care system, which leaves these women at a vulnerable place, as their health and quality of life are placed at risk. Jiwani further explained that immigrant women may be aware of the available services. However, they do not have the necessary knowledge about how the system works or how to access the available sources, which leads to their vulnerability and inequality within the system. Meriam continued her story: After spending two days suffering at home, she decided to go to the ED. When she first interacted with triage staff, who asked her about her family doctor, she felt anxious and afraid that she would not be allowed to get treatment because she did not have a family doctor. Meriam did not know the role of the family doctor, and she assumed that she had to have a family doctor to be seen in the ED. Thus, her limited information about the system placed her at risk by being afraid and anxious. She stated:

> She [the triage paramedic] took the vital signs and asked me about the family doctor. I did not open a file before, so it was something strange for me. If I did not have a family doctor, what would be the consequences? She didn't make me understand that it was just a routine there in the hospital, so I was afraid that I was supposed to have a family doctor to come to the emergency. What was the relation? Of course I did not know. I had no idea about it as it was my first time to go.

In the above scenario, Meriam did not ask for clarification nor did the paramedic explain the process to her. The paramedic may have assumed that Meriam knew about the system, whereas Meriam assumed that health care providers should know her needs without her verbally communicating those. This reaffirms what had been discussed in Chapter Four concerning the effect of culture on communication style. In other words, people in some cultures, such as Arabic culture, rely on nonverbal communication and assume that others understand their needs without clear verbal communication (Aboul-Enein & Aboul-Enein, 2010; Hamington, 2004; Srivastava, 2007).

Availability of information about the health care system and the ED is crucial. Participants in a study by Dastjerdi and colleagues (2012) described their overwhelming and frustrating experiences when they tried to look for educational resources about the Canadian health care system, and they pointed out that this was a process that needed a great deal of time, energy, and effort. Meriam indicated how knowledge about the system might contribute to finding better alternatives and decreasing the pressure and overcrowding in EDs. She stated: "When you know about the system, the way would be easy to get any services, in other words she would think to go to the family doctor better than waiting for a long time." Participant Safa similarly illustrated that education about the Canadian health care system is very important and mentioned that the hospital website had all the needed information in most of the common languages. She further urged that all that needed to be done was to advertise that these resources were available, and she emphasized that resources are indicative of cultural respect. She stated:

> When you access the hospital's websites, you can read your rights in whatever language you want. All languages are there. You will see that there are instructions about everything – who you will see first, where to go, what to do, about the prescriptions, about referrals. This is also a kind of cultural respect in the hospital's system. But nobody told me about it.

In the above example, Safa emphasized that language and culture, as well as the need for advertisement, cannot be overlooked when information is provided about the health care system. Paying attention to these aspects would help new immigrants to navigate the system easily and smoothly.

Culture and Knowledge about the Health Care System

Dastjerdi and colleagues (2012) stressed that limitations in language played an integral role in preventing some Iranian participants from accessing the Canadian health care system, insofar as some missed their appointments because they could not communicate with their doctors. Further, they could not find resources to educate themselves about the system in their language of origin, which contributed to their lack of understanding about the health care system. Other participants who could speak English were able to navigate resources to find valuable information about how the Canadian health care system worked and to offer help by educating newcomers who could not speak English. Similarly, Doaa, in her story, underscored that the language barrier was one of the major challenges that prevented her from understanding the differences between the systems in her home country and in Canada, which left her feeling lost and afraid in the ED. After she received the needed explanation about the system, her experiences became relaxed and positive. She said:

> I had just arrived [in Halifax], and did not know anything about how hospital system works here, and my English language skills were not that good. I did not know what to ask and how to ask it. I was afraid to say something that could be understood in a wrong way. I felt lost and was afraid. After a while, though, with the nurses' help, I relaxed, and we went through the whole procedure smoothly.

Participants in Lee and colleagues' (2014) study emphasized that even though some information was available and readily accessible in pamphlets in the waiting room in a Toronto clinic, these Canadian health resources for pregnant women in Chinese were not helpful in addressing all participant needs and questions. Thus, incorporating some suggestions about what is important and helpful in a certain culture in the educational materials is an idea that could be discussed at the institutional level, in order to determine the cultures of people who mostly use the health care system at this institution as well as the needs of these particular cultures. Doaa suggested that a box be placed in the EDs, where Arabs and other patients can write suggestions to be discussed and negotiated by policy makers. This suggestion would help to have the voices of these women heard, which in turn could facilitate and maintain equity within the Canadian health care system and prevent the marginalization of this group of users. She stated:

> There should be a suggestion box for us to write our suggestions. These suggestions should be discussed by the managers and decision-makers in hospitals in order to see what is applicable and doable.

Unfamiliarity with the Physical Settings in EDs

Unfamiliarity with the physical setting in EDs was reported by all participants in the study, in addition to general unfamiliarity with the system. Iman indicated that she was very hungry and that she did not know where to find food. Because of her unfamiliarity with the system, she did not anticipate waiting as long as she did and so didn't bring any food with her. Although they were directed by the security to Tim Hortons, Iman did not feel that this was a good food choice for a pregnant woman.

Hence, she suggested good restaurants with healthy food as a very important need not only for Arab immigrant women but for all patients in the ED. Iman did not mention specific kinds of food in the suggested restaurant. However, such a restaurant could include a variety of food selections in order to satisfy the need of people from different cultural backgrounds. That is to say, the menu should include vegetarian as well as non-vegetarian choices. Iman reported:

> Because it was our first visit, we did not expect it to be that long so we did not bring any food. I thought it would be an hour or two, maximum, but it was not. In addition, we did not know any place where we could buy food, and we were afraid that if we left to buy food, maybe they would call us and we would lose our turn. I was really starving, so my husband asked a security officer if there was a restaurant nearby. The security directed him to Tim Hortons. [Laughter.] It was not good for a pregnant woman, but it was the only place we knew … there should be a restaurant, a good one, nearby that sells healthy food so patients could buy healthy food while waiting.

The participants also unanimously agreed about the need for a prayer or a meditation room and guidance with regard to its availability. Safa indicated that no direction or guidance existed, even though valuable resources that meet Arab or Muslims' needs, such as prayer rooms, are available. She said: “Nobody told us that there is a quiet room if we want to use it. Everything is available, but there is no guidance at all.”

In the above stories, participants did not know if a prayer room was available or not, and Iman did not know if there was a restaurant in the ED or not. This demonstrated an urgent need for guidance and direction, which is also suggested by Nada and by Meriam. Displays such as signposting and posters on the walls or doors of EDs are necessary in order for people to find places easily and to avoid getting lost (Britten & Shaw, 1994; Stuart et al., 2003). Stuart and colleagues (2003) as well as Nada, a participant in the study, suggested brochures with a directory map of the ED. Nada stated: “In the waiting area, there [is] no a brochure that helps with the setting . . . If somebody is with you, they have to show where the cafeteria is, where they can go, because it would be difficult for a patient to go and ask about everything”; Meriam agreed with Nada's opinion and suggested an electronic directory map to help with the directions: “They can also have an electronic map that shows directions to where you can [get something to] eat or drink.”

Arab immigrant women struggled to navigate the Canadian health care system. This system has a structure, wait time, and priorities that are culturally, politically, and socially situated differently from Arab immigrant women's countries of origin. These differences made the system vague and complex to them, which consequently affected their lived experiences. They suffered pain, shock, frustration, and fear as they felt lost and unsupported by guidance or direction. The unfamiliar space of the ED invokes the opposite sense of feeling “at home.” It thus negates our notion of “being at home” and seems to instill fear, anxiety, stress, loss, and even pain. Whereas the notion of home, as Bachelard (1958) so eloquently reminds us, “is our corner of the world. As has often been said, it is our first universe, a real cosmos in every sense of the word. If we look at it intimately, the humblest dwelling has beauty” (p.4). Even though unfamiliarity with the emergency setting and/or the system could be a problem for a Canadian woman who visits the ED for the first time, language and culture would most likely not be problematic, and such a person could handle the situation more easily. This chapter illuminated how unfamiliarity, along with language barriers and cultural differences, played significant roles in making the lived experiences of Arab immigrant women more difficult and unsatisfactory. These women shared suggestions that could help them to access and pass through the system with more knowledge and therefore less fear, stress, and uncertainty.

Chapter Seven

Final Reflections

To look inside one's self and honestly determine one's shortcoming is the first cornerstone in constructing a better self. I argue that critiquing current practices for the purpose of restructuring, constructing, and advancing one's culture requires a meaningful look within. (Hamdan, 2009a, p. 185)

The main purpose of this research was to provide an in-depth understanding, through a feminist phenomenological approach, of the experiences of Arab immigrant women, their cultural values and beliefs, their attitudes, and their interactions with health care providers when accessing the Canadian health care system in the context of EDs in HRM. Through the retelling of participants' stories, administrators, educators, policy makers, and health care providers, will better understand the women's experiences, both positive and negative, thus potentiating improved care provision for this often under-represented population of women in health care, education and research. Four themes emerged from these women's stories and researcher interpretation: Engagement in Cultural Care with Health Care Providers, Disengagement and Cultural Care, Suffering in Pain While Waiting, and I am lost! Help Me Please!

The first theme, *Engagement in Cultural Care with Health Care Providers*, defined and illuminated engagement as experienced by Arab immigrant women. Their stories showed how the first moment of an interaction between the women and health care providers was crucial in enhancing their engagement throughout their stay in EDs. Smiling when culturally appropriate, self-introduction, and sharing relevant personal information helped to alleviate the anxiety associated with being in a place from a different cultural background, all of which promoted their engagement. Providing personalized holistic care was another aspect of care that facilitated Arab immigrant women's engagement as culturally sensitive. Holistic care included paying attention to concrete, physical symptoms as well as to the emotional, spiritual, cultural, and social aspects considered important by Arab immigrant women in health care decisions and care. Arab immigrant women who received this kind of embodied care were satisfied and engaged positively with their care providers.

Verbal and nonverbal communication were other important aspects when providing care to Arab immigrant women, as effective communication with their health care providers facilitated the engagement process. Communication was an important indicator for the degree of cultural respect needed to build trustful relationships that were, in turn, needed for engagement. The women suggested that health care providers would benefit from an awareness of these aspects of care that promote the engagement process. Paying attention to these small behaviors they argued would make a significant difference to their future experiences in EDs.

When health care providers did not approach Arab immigrant women with introductions, and avoided eye contact or self-disclosure, a power imbalance was created and the chance for disengagement increased. These issues were discussed in the second theme, *Disengagement and Cultural Care*. In the above-mentioned attitudes, Arab immigrant women felt that nurses and other health care providers were not able to provide the individualized and the holistic care needed, as providers were not paying attention to their emotional and/or cultural values. Further, cultural verbal and nonverbal miscommunication played significant roles in reducing the opportunity for Arab immigrant women to engage with their health care providers. Language difficulties with no explicit and clear communication contributed to misinterpretation and disengagement, which emphasized the current need for interpreters who are professional in interpreting verbal and nonverbal communication. Lack of awareness, knowledge, and/or desire to work with Arab immigrant women made such health care providers insensitive to the needs of this group of women and eventually led to some patient distrust not only of health care providers but of the system as a whole.

The effects of lived time and lived space on the experiences of Arab immigrant women in the EDs in HRM were discussed in the third theme, *Suffering in Pain While Waiting*. The overarching stories discussed by these women were indicated by lengthy wait time and uncomfortable physical settings. The long waiting because of the crowds and understaffing contributed to these women's dissatisfaction and jeopardized their safety. Health care providers, from one perspective, were rushed to make decisions to speed the flow of the patients and patients, from another perspective, were suffering from pain and other symptoms that were exacerbated as a result of the wait. Anxiety, frustration, and impatience were reported by Arab immigrant women as psychological symptoms were caused by the wait and further affected their physical symptoms. Bio-psycho-social symptoms of waiting were aggravated by seeing other patients suffering while sitting in uncomfortable chairs in a cold, unclean, and gendered-mixed area.

The fourth and final theme, *I am lost! Help Me Please!*, discussed Arab immigrant women's unfamiliarity with the Canadian health care system as a whole and with the settings in EDs; it also discussed how language and communication barriers, along with cultural differences, complicated their experiences. The differences between health care systems in their home countries and in Canada was their major stressor. The role of family doctors, for example, was one major concern for these women as they were not familiar with this role in their home countries, and this lack of knowledge forced them to visit EDs instead. The lack of a private health care system in Canada was another major source of their confusion, frustration, and uncertainty that put them in a vulnerable place. In the EDs, they were lost as they did not know where to go, what to do, whom to ask, where to get food, and where to pray and/or meditate. This problem was further complicated by a language barrier, as they did not know how to ask for things they needed, and by a lack of knowledge and educational resources about the system. Adaptation to the new Canadian system is necessary to prevent Arab immigrant women from being isolated and hesitant to access the health care system when needed.

Although the findings from the research are specific to Arab immigrant women in EDs, they have transferability to other immigrant populations and/or other health care settings. Immigrant women, for example, often share similar values and/or encounter similar challenges, including the value of collectivism amongst many Asian, Indian, and Mexican women as a cultural belief in which family members are important decision- makers in their lives (Cong & Silverstein, 2012; Nath & Craig, 1999; Sarkisian, Gerena, & Gerstel, 2006). Thus, study findings could potentially be useful when collaborating with these women in health care settings. Likewise, smiling when culturally relevant, engaging a caring attitude, and appropriate touch provide further examples of study findings relevant beyond ED settings. This suggests a need for future studies to explore the applicability of the findings to other clinical areas and with other immigrant populations.

Implications for Practice, Research, and Education

Given the findings, transferring knowledge into practice is imperative. Understanding the experiences of Arab immigrant women enabled health care providers to realize how such experiences could be improved with attitude-related behavioral changes, such as genuine smiling, touch, and eye contact—as culturally relevant. Participants in the study, however, discerned that some health care providers' attitudes were the result of understaffing and a heavy workload, which were in the hands of hospital management. Thus participants shared many suggestions to help health care providers do their job effectively while meeting patient needs, including patients with different backgrounds. Because long wait times were a problem for most participants, many suggestions were given to reduce the wait or make it bearable.

Time estimation was a solution suggested by Arab immigrant women in cases where a long wait cannot be avoided. This solution could decrease patients' anxiety and uncertainty and enhance their satisfaction (Kihlgren et al., 2004; Thompson & Yarnold, 1995). Iman suggested:

> They should give patients an approximate time they'll have to wait, in order to prevent unnecessary waiting. If I had known I would have to wait that long, I could have gone to buy food or do something else and then come back an hour before my estimated time.

Iman indicated that she would have left to buy food if she knew when approximately her turn would be; without that information, she was afraid to leave to buy food as she might miss her name being called and lose her turn. Her turn was a priority for her even though she may get sicker by not eating; with pregnancy, eating healthy food is of crucial importance to nourish the mother and the fetus. Meriam echoed what Iman suggested and explained that she would have gone to see her children, eat, drink, and do other activities instead of waiting in the emergency lobby if she knew approximately how long she would wait. She stated:

> Another idea . . . is to estimate the time if there is a possibility. For example, I was afraid to use the washroom because I thought they might call me at that time. I was hungry and thirsty, but I was afraid to leave to get something to eat or drink. I waited for eight hours; it was not logical that we would not want to eat or go out. I could have gone to get my kids and come back, if the time allowed.

Meriam's idea is similar to what Asplin and colleagues (2003) created for emergency room crowds' estimation. They developed an input-throughout-output conceptual model. In this model, *input* included the number of patients entering the emergency department, *throughout* reflected the time in which a patient is taken care of, and *output* referred to the times that delayed the discharge of patients. Meriam shared a similar suggestion when she stated: “time is an important issue, so they should take notes when patients come and when they leave.” Meriam, further, pointed out that the emergency department has a screen with information about the number of patients, in which time could be estimated. In a study by Corbett, While and Wittlake

(2000), a screened video message with a wait time enhanced patient satisfaction. For Meriam, however, the screen was difficult to understand; she described how language made understanding difficult, and she suggested that the screen have a language selection choice:

> I think [it would be good] if the screen had the option to select a language. I mean, the screen that has all of the information [about] how many patients there are, who's entered, who's left, and the time. Sometimes, there are cases brought by ambulance, so you have to wait for them, and this can delay your turn by an hour or so [and all information is there]. Actually, I took 15 minutes to figure out the screen. But for somebody who does not speak English and does not have a nursing background, I don't think she would understand. If somebody would explain it to her, this would make the situation better . . . But it was not easy to understand the screen, and it was not translated into other languages.

In addition to these language and communication issues, participants discussed other cultural issues, including those related to gender. The gender-mixed waiting area was brought to my attention in every single interview as well as in the group interview. Many suggestions were shared to address this issue. A suggestion by most of the participants was to have more than one waiting area, in order for the place to be quiet and less crowded. Meriam suggested: "It has to accommodate a limited number of people, with more than one waiting area." Safa echoed what Meriam said by suggesting specialized waiting areas for each disease category: "There must be sections in the waiting area, a section for miscarriage, a section for orthopedics. It should be separated so it would not be crowded." Iman emphasized that having more than one waiting area would not only promote comfort but also would reflect cultural understanding:

> The waiting area was mixed-gendered, so they maybe did not understand our culture. Otherwise, they may have offered at least a room, even a small one, for women who do not feel comfortable in a mixed-gendered room . . . The waiting area should be larger, with more than one section. One section could be only for women. There could be an area for both men and women, if a woman wants to stay with her husband.

Nada indicated that having a specific place for women not only in the waiting areas but also inside the examining rooms would show that health care providers and the Canadian health care system as a whole care about privacy, which in turn affects patients' psychological states. Evidence suggested that participants reported privacy as an issue in EDs, especially with doors being opened and curtains being easily pulled up by staff or by other people looking for their relatives (Baraff et al., 1992; Britten and Shaw, 1994; Kihlgren et al., 2004). Nada said:

> I mean, there [should be] privacy, women alone and men alone . . . So in hospitals, there is a thing called privacy for covered and non-covered women. A covered woman cannot be exposed, and there was a man with me in the same room. There was also a watcher with him who was a man, and there was only a curtain between us . . . I suggest that there be specified rooms. A place like an emergency should have rooms for physical examinations for only

> women . . . [It affects] patient psychology. She would be relaxed. If she is exposed or something like that, there would be no men beside her.

When speaking about the issue of education in improving their experiences with the Canadian health care system, participants had useful suggestions for administrators and policy makers. Meriam indicated that assessment and education about the system should take place from the beginning of the immigration process. She suggested health care websites for newcomers and/or educational sessions at language institutions to enhance Arab immigrants' awareness of the Canadian health care system in general and of emergency departments in particular. The long wait and the prioritizing of emergency cases, as well as the role of walk-in and family doctors' clinics, should be important topics for discussion with new immigrants and would prevent their struggling with the system. She said:

> They should let her [an Arab immigrant woman patient] knows that you have to wait for a long time, so you do not need to go back and forth and ask before they call you. Knowing these stuff has to be from the beginning when she gets the health insurance … So I think there should be assessment on how Arabic people comprehends these things. Furthermore, each student has to know about emergency cases. Each student has to know that there are priority cases, which are the ones that come by the ambulance, and that the other cases that have another name “walk-in” are not urgent, so if they could not bear the waiting, they have to go to the family doctor … For example, as we knew the importance of health insurance, and went to make registration. From where we got the information [about the health insurance]? We got the information from

> language institutions or from the web [page]. Therefore, we have to get same explanation [about the system].

Ads and other educational materials could be placed in areas where most Arabs visit, such as Mosques and Arab community centers. Cottrel (2005/2006) suggested an establishment of organizations to widely spread the materials to immigrant women. Iman echoed what Meriam and Safa said and pointed out the importance of educational sessions and lectures in places with significant numbers of Arab immigrants, such as mosques and language centers. She suggested topics for discussion that included locations of hospitals, services provided, and general information about the health care system. She reported:

> I think it is important to educate the newly comers about the health system in general. About the emergency, the clinics, the family doctors, appointments, and hospitals' locations, services, everything they think are important for us to know. We were new, we did not know. The education sessions or lectures or whatever, should be in a commonly visited place. Mosques are really good places with lots of Arabs. Also, English language schools, there are a lot of immigrants.

Even though such suggestions are possible to do and essential for a positive experience of Arab immigrant women accessing the Canadian health care system, policy makers may not be aware of such suggestions. Thus communicating the results of this study to health policy makers and to institutional administrators is integral to have the voices of these women heard and their needs met. Communicating results could occur through formal or informal means. Informal conversations with managers and policy makers could have an effect. For example, some of the results were shared during a conversation with Kewoba Carter, an immigrant Muslim women representative at Dalhousie University and a member of a committee that discusses policy and procedures related to diversity in health care initiatives, as they are in the process to build a new health care center on campus. She met with the committee members on April, 2nd/2014; the purpose of the committee meeting was to identify prospective priorities for changes in policy and practice when building the new on-campus health care center. Their question was “what must be different this time to get different results than we have seen before?” Policy makers wanted to examine what immigrants need when visit the health care center and how their needs could be addressed to avoid any previous fault when immigrants access this health care center. Kewoba shared preliminary findings from this study and they were well received.

Publications and presentations at conferences, seminars, and in-services are formal ways to translate findings from the study not only to policy makers and management but also to health care providers, educators, and researchers. Health care providers may become more vigilant and start to reflect on their own practice when dealing with Arab immigrant women, based on the results of this study. Faculty members and educators may also start to think differently in how to incorporate some of the study findings into their curricula. For example, a study by Chircop and colleagues (2013) examined current audiovisual tools used for physical assessment in Canadian nursing schools and evaluated theses tools for the inclusion of cultural assessment. They found that majority of participant schools did not address cultural competency in their physical and health assessments. Hence, the results of this study could potentially be useful in extending the aforementioned findings, thus showing the need for more cultural diversity in health care assessment, including that of Arab immigrant women.

This study also offers an initial area of study for Arab immigrant women and is thus a platform in which to further research with this often under-represented population of women. Insofar as this study examined this population entering EDs in HRM and were a specific demographic of educated women, future studies are necessary to further understand Arab immigrant women experiencing health care in other areas and demographics. For example, researchers could study the experience of Arab immigrant women who are not highly educated or not educated when they access the Canadian health care system. Researchers could also explore influence of the nature of participants' diseases and their diseases' urgency on their experiences__ for example, would the experience be different for an Arab immigrant women with cardiac or respiratory problems requiring urgent care as compared to the experience of an Arab immigrant woman with abdominal pain.

Self-Reflection

Van-Manen (1997) claimed that phenomenological inquiries create a connection between “research and life“ in which “phenomenological engagement is always personal engagement: it is an appeal to each one of us, to how we understand things, how we stand in life, how we understand ourselves” (p.156), and this philosophy is intended, with our deep thinking, to change our thinking and actions, as it creates a space of personal and contextual engagement with the stories (Ryan, 2007). With self-reflection and sharing of a personal experience, especially in countries with past-oriented group who strongly maintain their culture and traditions and have no or little motivation for change (Giger & Davidhizar, 2002), the researchers are empowered as sharing part of their lives “is an act of rebellion for [women] who [were] brought up to believe that a “good behaving” woman should neither disturb nor critique her cultural traditions” (Hamdan, 2009a, p. 184).

After listening to and reflecting on these women's stories, I deeply understand how challenging the experiences of immigrants can be, and my way of thinking has been reshaped; my nursing practice and approach to patients will never be the same. I learned that I have to be cautious as a nurse when dealing with patients from other cultures and to be vigilant not only in understanding their verbal communication but also to my own: verbal and non-verbal signs and cues, as we all communicate an important part of our culture with nonverbal signs--patients and providers. I realized that culture goes far beyond the verbal and spoken words and started to think how I can include culture as an important piece of patient assessment; I will now react differently when interacting and communicating with patients from other cultures, especially women, as they have unique needs different from those of men, even those men with whom they share the same culture. I will spend more time with patients to understand their cultures and will not be afraid or ashamed to ask about their cultures and their unique preferences, as this would help me become a better nurse who provides culturally congruent and safe care as seen by patients—and remember, there is something rather magical in learning about other cultures. We cannot be afraid to remain interested. This doesn’t mean we are not competent—although there will always be things we don’t know, but as long as we have a baseline of knowledge, it is important that we are generous and loving in our asking and use the opportunity to co-create something with those who we are privileged to care. I will become a better advocate for patients' needs by providing holistic patient-centered care. I also learned that care as a caring attitude is what patients in EDs need. The care that entails the “loving” attitude; “honoring” patients' needs, hopes, cultures, and routines; maintaining the “inner harmony” and the wholeness of the “body, mind, and spirit”, along with the “authentic presence” that has the "intention of “doing” for another and “being” with another who is in need” (Watson Caring Science Institute, 2010, p.1). As a result, I will start to check on patients, as time permits, to ask about their feelings and symptoms, as this may positively affect their psychology by decreasing their tension and anxiety and eventually their physical conditions. I became aware that “one encounter ... negative or positive ... can change the course of [a] person's life [, and] those encounters create the backdrop of the personal, professional, and social contexts in which we live” (Ryan, 2007, p. 119).

As an educator, I realized that patient culture should be a basic element in nursing curricula, and I will start to examine different cultural assessment tools to determine what could be useful to include at the university where I will be working as well as how to include culture as a fundamental part of assessment at nursing schools. A useful cultural assessment tool includes criteria to examine the dominant culture within a culture as well as the uniqueness of individuals, in order to reflect deep respect of both their cultural and their unique needs, as there are elements that are shared within a culture but nurses should be aware not to essentialize, remaining vigilant to individual difference. Measuring cultural competence is another important issue when providing care to diverse populations and thus an issue for educators to address. Kumas-Tan, Beagan, Loppie, Macleod, and Frank (2007) argued that it is difficult to measure cultural competence and that current measures are questioned for their reliability and utility. Issues and assumptions in current measures should be examined and solved. Kumas-Tan and colleagues (2007) presented some of the assumptions after examining available measures. One of these assumptions was that interactions with diverse people in health care settings increase knowledge and skills about other cultures. They argued that such interactions imply messages from the providers (verbal and nonverbal) that may empower or marginalize some of cultural practices of their patients. Cultural knowledge and skills should be obtained from formal resources or settings other than hospitals. This, however, should not weaken the importance of direct interactions as a main construct to become culturally competent.

Phenomenological writing has been a deep learning experience for me in this journey. Understanding the power and poetry of language is inherent to phenomenological writing: What is inside and through spoken language is imperative to phenomenological writing to express the storied experience required to stimulate readers and to elicit their responses (Ryan, 2007).

Van Manen (1990) asserted that phenomenological writing requires skills to convert the invisible content of the words into something visible, and this in turn requires "a complex process of rewriting, re-thinking, re-flecting, [and] re-cognizing ... going back and forth between the parts and the whole in order to arrive at a finely crafted piece that often reflects the personal "signature" of the author" (p. 132-133).

Yet, within this research, the ability to write for readers who had different cultural backgrounds became a priority: learning to write clearly and with in-depth knowledge about cultural and/or religious beliefs shared by women participants. Hamdan (2009a) claimed that “[w]estern audiences are [not] as intimately acquainted with Arab Muslim cultural traditions as” she was, and she was cautious in her writing, as some expressions and values could be interpreted negatively by outsiders (p. 183).

The stories shared by Arab immigrant women are pieces “of art that [are] colorful and rich” (Hamdan, 2009a, p. 192). Each participant woman brought her own belief, values, orientation, worldview, historical (Ryan, 2007), political, social, and cultural backgrounds to this particular experience (Hamdan, 2009a). These women have a power hidden within them, but because of cultural constraints, most of them were unable to speak up and communicate their needs to policy makers and health care providers.

An objective of the study is that the phenomenological stories, through their gender-based analysis, will contribute a deeper understanding of Arab immigrant women’s culturally embodied experiences in EDs in HRM. This potentiates a change in care provision, specifically as it relates to policy development, educational curricula, and provider-consumer relationships in EDs in HRM. This in turn optimizes care for this often under-represented population of women, increases their health outcomes and potentiates equity for all persons living in Nova Scotia. As Jiwani (2001) so aptly reminds us “structural change remains the only viable solution if we are to meet the needs of immigrant women of colour and truly achieve the expectations of a health care system that is universal, humanitarian, and compassionate. Until then, we will continue to have a system that perpetuates inequalities" (p. 61).

Despite the Canadian health care system being seen as "equitable and non-discriminating," evidence suggests that current Canadian immigration policies that are based on gender, race, and social relations further contribute to the marginalization and oppression of immigrant women (O'Mahony & Donnelly, 2007; 2010; Jiwani, 2001). Being an immigrant woman within the health care system in Canada places one at double the risk of oppression. Thus Arab immigrant women are at risk of "double jeopardy" and, hence, reduce their opportunity of receiving equitable health care. Beale (1969), who examined the condition of black women in the US, discussed why black women were being oppressed in relation to both race and gender, thus giving rise to the notion of "double jeopardy." While the situation of women in patriarchy was often simplified, according to Beale, reducing women's roles to biological functioning and raising children diminished the contributions of black women to the liberation movement.

My realization has been built throughout this journey that each methodology and approach has its knowledge to enrich this research, and that they all have interwoven to produce this piece of writing. Existential phenomenology with an interpretive lens helped to provide an in-depth understanding of the participants' experiences and of how participants were affected by their interactions with others and with the surrounding environment. These experiences could not be interpreted from women perspectives without feminist theory that further helped in looking into solutions from women's perspective to empower them within their society. The interpretation and the suggested solutions were, however, based on the knowledge of Arab culture and how culture and Islam guided the lives of these women. Thus the work could not be accomplished without the connections between them as well as the understanding of what each constitutes.

References

Aboul-Enein, B.H., & Aboul-Enein, F. (2010). The cultural gap delivering health care services to Arab American populations in the United States. *Journal of Cultural Diversity,* 17, 20-23. Retrieved from CINAHL Full Text database.

ABNAC, CASN, & CNA. (2009). *Cultural competence and cultural safety in First Nations, Inuit and Metis nursing education. An integrated review of literature*. Retrieved from https://www.uleth.ca/dspace/bitstream/handle/10133/720/An_Integrated_Review_of_the_Literature.pdf?sequence=1

Afshar, H. & Maynard, M. (2000). Gender and ethnicity at the millennium: From margin to center. Ethnic and Racial Studies, 23, 805-819. Retrieved from http://www.tandfonline.com/doi/abs/10.1080/01419870050110904

AlMutair, A., Plummer, V., O'Brien, A., & Clerehan, R. (2014). Providing culturally congruent care for Saudi patients and their families. *Contemporary Nurse*, 46, 254-258. Retrieved from CINAHL Full Text database.

Almutairi, A., Rondney, P. (2013). Critical Cultural Competence for Culturally Diverse Workforces Toward Equitable and Peaceful Health Care. *Advances in Nursing Science,* 36, 200-212. Retrieved from CINAHL Full Text database.

Al-Shah, S. M., Ayash, C., Pharaon, N.A., & Gany, F. M. (2008). Arab American immigrants in New York: Health care and cancer knowledge, attitudes, and beliefs. *Journal of Immigrant and Minority Health,* 10, 429-436. doi: 10.1007/s10903-007-9106-2

Al-Shahri, M. Z. (2002). Culturally sensitive caring for Saudi patients. *Journal of Transcultural Nursing,* 13, 133-138. doi: 10.1177/104365960201300206

Amaratunga, C. (Eds.). (2002). *Race, ethnicity, and women's health*. Halifax, Nova Scotia, Canada: Atlantic Center of Excellence for Women's Health.

American Health Information Management Association Journal. (2012). Patient engagement important, but definitions vary. *American Health Information Management Association Journal,* 83, Retrived from http://www.ncbi.nlm.nih.gov/pubmed/22991794

Amjad, M. (2011). *Islamic Feminism and the future of women Rights in Moslem World*. Retrieved from CINAHL Full text database.

Andrews, M. & Boyle, J. (2008). *Transcultural concepts in nursing care*. Philadelphia: Lippincott Williams & Wilkins.

Annells, M. (1996). Hermeneutic phenomenology: Philosophical perspectives and current use in nursing research. *Journal of Advanced Nursing*, 23, 705-713. Retrieved from CINAHL Full Text database.

Aranda, K. (2006). Postmodern feminist perspectives and nursing research: A passionately interested from an inquiry. *Nursing Inquiry Journal*, 13, 135-143. Retrieved from CINAHL Full Text database.

Asplin, B., Magid, D., Rhodes, K., Solberg, L, Lurie, N., & Camargo, C. (2003). A conceptual model for emergency department crowding. *Annuals of Emergency Medicine*, 42, 172-180. doi: 10.1067/mem.2003.302

Bachelard, G. (1958). The House. From cellar to garret. The significance of the hut. In *The poetics of space* (Chapter 1). Retrieved from http://poetry.rapgenius.com/ Gaston-bachelard-the-poetics-of-space-chap-1-annotated.

Back, E., & Wikblad, K. (1998). Privacy in hospital. *Journal of Advanced Nursing*, 27, 94-945. Retrieved from CINAHL Full Text database.

Balls, P. (2009). Nursing practice. Phenomenology in nursing research: methodology, interviewing and transcribing. *Nursing Times*, 105, 30-33. Retrieved from CINAHL Full Text database.

Baraff, L.J., Bernstein, E., & Bradley, K. (1992) Perceptions of emergency care by the older: results of multicenter focus group (group interview) interviews. *Annuals of Emergency Medicine,* 21, 814–818.

Beale, F. M. (1969). Double jeopardy: To be black and female. In T. C. Bambara (Ed.), *The black woman, an anthology* (pp. 109-122). New York: Pocket Books.

Bechtel, G., Davishizar, R., Rouge, B., & Mishawaka (1999). A cultural assessment model for ED patients. Journal of Emergency Nursing, 25, 377-380. Retrieved from CINAHL Full text database.

Bench, S., Day, T., & Griffiths, P. (2011). Involving users in the development of effective critical care discharge information: A focus group (group interview) study. *American Journal of Critical Care*, 20, 443-452. Retrieved from CINAHL Full Text database.

Benner, P. (1994). *Interpretive phenomenology: Embodiment, caring, and ethics in health and illness.* Retrieved from http://web.b.ebscohost.com.ezproxy.library.dal.ca/ehost/ebookviewer/ebook/bmxlYmtfXzQ3MzczOF9fQU41?sid=aa40bf60-c647-48b5-a75e-a5acdfc4d415@sessionmgr115&vid=1&format=EB&rid=1

Bennett, T. (2013). *Nursing skills for the emergency room.* Retrieved from http://www.ehow.com/list_6788363_nursing-skills-emergency-room.html

Borkan, J., & Neher, J. (1991). A developmental model of ethnosensitivity in family practice training. *Family Medicine*, 23, 212-217. Retrieved from CINAHL Full Text database.

Brach, C. & Fraser, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review,* 57,181-217. Retrieved from CINAHL Full Text database.

Bradley, V. (2005). Placing emergency department crowding on the decision agenda. *Journal of Emergency Nursing*, 31, 247-258. Retrieved from CINAHL Full Text database.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in Psychology,3,* 77-101. Retrieved from PubMed database.

Brookfiled, S. (2009). The concept of critical reflection: Promises and contradictions. *European Journal of Social Work*, 12, 293-304. Retrieved from CINAHL Full text database.

Brown, P. R. (2008). Trusting in the New NHS: instrumental versus communicative action. *Sociology of Health and Illness*, 30, 349–363. Retrieved from CINAHL Full Text database.

Brown, P. R. (2009). The phenomenology of trust: A Schutzian analysis of the social construction of knowledge by gynae-oncology patients. *Health, Risk & Society*, 11, 391–407. doi: 10.1080/13698570903180455.

Britten, N. & Shaw, A. (1994). Patients' experiences of emergency admission: how relevant is the British government's Patients Charter? *Journal of Advanced Nursing*, 19, 1212-1220. Retrieved from CINAHL Full Text database.

Burely, D. (2011). Better communication in the emergency department. *Emergency Nurse*, 19, 32-36. Retrieved from CINAHL Full Text database.

Byrne, M. (2001). Interviewing as a data collection method. *Association of Operating Room Nurses Journal,*72, 233-235. Retrieved from CINAHL Full Text database.

Cameron, B. (2004). Ethical moments in practice: The nursing 'how are you?' revisited. *Nursing Ethics*, 11, 53-62. Doi: 10.1191/0969733004ne666oa.

Campbell-Yeo, M., Latimer, M., & Johnston, C. (2008). The empathetic response in nurses who treat pain: concept analysis, *Journal of Advanced Nursing*, 61, 711–719. doi: 10.1111/j.1365-2648.2007.04562.x

Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare services: A model of care. *Journal of Transcultural Nursing*, 13, 181-184. doi: 10.1177/10459602013003003

Canada and the World. (2012). *Women in the Arab World*. Retrieved from http://www.canadaandtheworld.com/womeninarabworld.html

Canadian Nursing Association (2008). *The Canadian registered nurse exam prep guide* (4th ed.). Ottawa, Ontario, Canada: Author

Carman, K. L., Dardess, P., Maurer, M., Sofaer, Sh., Adams, K., Bechtel, C., & Sweeney, J. (2013). Patient and family engagement: A framework for understanding the elements and developing interventions and policies. *Journal of Health Affairs,* 32, 223-231. Doi: 10.1377/hlthaff.2012.1133

CBC News. (2014). *N.S. health minister hopes midnight sitting will resolve nursing strike: Essential services legislation would order nurses back to work.* Retrieved April 24th, 2014, from http://www.cbc.ca/news/canada/nova-scotia/n-s-health-minister-hopes-midnight-sitting-will-resolve-nursing-strike-1.2596602

Chircop, A., Edgecombe, N., Hayward, K., Ducey-Gilbert, Ch., & Sheppard-LeMoine, D., (2013). Evaluating the integration of cultural competence skills into health and physical assessment tools: A survey of Canadian schools of nursing. *Journal of Transcultural Nursing*, 24, 195-203. doi: 10.1177/1043659612472202.

Choi, J. (2009). Contextual effects on health care access among immigrants: Lessons from three ethnic communities in Hawaii. *Social Science and Medicine*, 69, 1261-1271. doi:10.1016/j.socscimed.2009.08.001

Choi, J. (2013). Negotiating old and new ways: contextualizing adapted health care-seeking behaviors of Korean immigrants in Hawaii. *Journal of Ethnicity & Health*, 18, 350-366. Retrieved from CINAHL Full Text database.

Cohen, E., Wilkin, H., Tannebaum, M., Plew, M., & Haley, L. (2012). When patients are impatient: The communication strategies utilized by emergency department employees to manage patients frustrated by wait times. *Health Communication*, 28, 275-285. doi: 10.1080/10410236.2012.680948

College of Medical Association. (2004). *CMA code of ethics*. Retrieved from http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf

College of Registered Nurses of Nova Scotia. (2012). *Standards of practice for registered nurses.* Retrieved from http://www.crnns.ca/documents/RNStandards.pdf

Cong, Z. & Silverstein, M. (2012). Caring for grandchildren and intergenerational support in rural China: A gendered extended family perspective. *Ageing & Society*, 32, 425-450. doi: 10.1017/S0144686X11000420.

Corbett, S., While, P., & Wittlake, W. (2000). Benefits of an informational videotape for emergency department patients. *American Journal of Emergency Medicine,* 18, 67-71.

Cottrell, B. (2005/2006). *Providing services to immigrant women in Atlantic Canada*. Retrieved from http://www.google.com.sa/url?url=http://canada.metropolis. net/pdfs/Pages_from_ODC_spring08_e.pdf&rct=j&frm=1&q=&esrc=s&sa=U&ei=-L_LU9jFCePf4QTXgYG4Aw&ved=0CBcQFjAA&usg=AFQjCNH YrxBYs_0uMUI-ieSIrCjDCayVoA

Coulter, A. (2012). Patient engagement- What works. *Journal of Ambulatory Care Management*, 35, 80-89. doi: 10.1097/JAC.0b013e318249e0fd

Crabtree, V. (2011). *The Islamic religion is often mixed with cultural practices.* Retrieved from http://www.vexen .co.uk/ religion/islam _religion _and _culture.html

Creswell, J. W. (2007). Philosophical, paradigm and interpretive frameworks. In J. W. Creswell (Ed.), *Qualitative inquiry and research design: Choosing among five approaches* (pp. 15-33). Thousand Oaks, CA: Sage.

Dastjerdi, M., Olson, K., & Ogilvie, L. (2012). A study of Iranian immigrants' experiences of accessing Canadian health care services: A grounded theory. *International Journal for Equity in Health,* 11, 55-70. Retrieved from PubMed database.

Davidhizar & Giger, D. (1998). *Canadian transcultural nursing: Assessment and intervention*. California: Mosby.

Davis, M. (2000). *Communicating nonverbally with non-English speaking multicultural emergency room patients: An educational module for nurses.* Retrieved from ProQuest Dissertations & Theses database.

Davis, M., & Heineke, J. (1998). How disconfirmation, perception, and actual waiting times impact consumer satisfaction. *International Journal of Service Industry Management*, 9, 64- 73.

Dawood, M. (2005). Patient centred care: lessons from the medical profession. *Emergency Nurse*, 13, 22-27. Retrieved from CINHAL Full Text database.

Derlet, R. & Richards, J. (2000). Overcrowding in the nation's emergency departments: Complex causes and disturbing effects. *Annuals of Emergency Medicine,* 35, 63-68. Retrieved from CINAHL Full Text database.

DeSantis, L. & Ugarriza, D. (2000). The concept of theme as used in qualitative nursing research. *Western Journal of Nursing Research,* 22, 351-372. Retrieved from CINAHL Full Text database.

Dictionary.com (n.d.). In *Dictionary.com*. Retrieved March, 12, 2014, from http://dictionary.reference.com/etymology/

Dimond, B. (2005). Consent to treatment records. British Journal of Nursing, 14, 1024-1027. Retrieved from CINAHL Full Text database.

Dinc, L. & Gastmans, Ch. (2012).Trust and trustworthiness in nursing: an argument-based literature review. *Nursing Inquiry*, 19, 223-237. doi: 10.1111/j.1440-1800.2011.00582.x

Dinc, L. & Gastmans, Ch. (2013). Trust in Nurse-Patient Relationships: A Literature Review. *Nursing Ethics*, 25, 501-516. doi: 10.1177/0969733012468463.

Dong, D. & Temple, B. (2011). Oppression: A concept analysis and implications for nurses and nursing. *Nursing Forum*, 46, 169-176. Retrieved from CINAHL Full Text database.

Dowling, M. (2004). Hermeneutics: An exploration. *Nursing Researchers*, 11, 30-39. Retrieved from CINAHL Full Text database.

Dowling, M. (2006). Approaches to reflexivity in qualitative research. *Nurse Researchers Journal*, 13, 7-21. Retrieved from CINAHL Full Text database.

Dowling, M. (2007). From Husserl to van Manen. A review of different phenomenological approaches. *International Journal of Nursing Studies*, 44, 131-142. dpi: 10.1016/j.ijnurstu.2005.11.026

Draucker, C. (1999). The critique of Heideggarian hermeneutical nursing research*. Journal of Advanced Nursing*, 30, 360-373. Retrieved from PubMed database.

Drew, N. & Dalhberg, K. (1995). Challenging a reductionist paradigm as a foundation for nursing. *Journal of Holistic Nursing*, 13, 332, 345. Retrieved from PubMed database.

Eadie, C. (2014). Health literacy: A conceptual review. *Academy of Medical-Surgical Nurses.* 23, 10-13. Retrieved from CINAHL Full Text database.

Erickson-Owens, D., Good, D., & Zdenek, R. (1988). *Removing cultural barriers to care during childrearing: A continuing education module.* Retrieved from ProQuest Digital Dissertations.

Fallon, A. (2005). Culture within a culture: US immigrants confront a health system that may citizens can't manage. *Ethics Journal of the American Medical Association*, 7, 1-5. Retrieved from http://virtualmentor.ama-assn.org/2005/07/msoc1-0507.html

Feri, J. & Shaver, Ph. (2002). Respect in close relationships: Prototype definition, self-report assessment, and initial correlates. *Personal Relationships*, 9, 121-139. doi: 10.1111/1475-6811.00008

Festin, M. (2014). Nausea and vomiting in early pregnancy. *Clinical Evidence*, 2014, 1405. Retrieved from PubMed database.

Festini, F., Focardi, S., Bisogni, S., Mannini, C., & Neri, S. (2009). Providing transcultural to children and parents: An exploratory study from Italy. *Journal of Nursing Scholarship*, 41, 220-227. Retreived from PubMed database.

Fields, S. (2007, February 6). Eye (contact) for an eye. *Washington Times*. Retrieved from Regional Business News database.

Finch, L. (2004). Understanding patients' lived experiences: The interrelationship of rhetoric and hermeneutics. *Journal of Nursing Philosophy*, 5, 251-257. Retrieved from CINAHL Full Text database.

Forbes D.A., King D.M., Kushner K.E., Letourneau N.L., Myrick F.A. & Porfetto-McGrath J. (1999). Warrantable evidence in nursing science. *Journal of Advanced Nursing*, 29, 373–379. Retrieved from CINNHL database.

Gadow S. (1994) Whose body? Whose story? The question about narrative in women's health care. *Soundings: An International Journal*, 77, 295-307. Retrieved from PubMed database.

Gibbs, K. (2005). Teaching student nurses to be culturally safe: Can it be done? *Journal of Transcultural Nursing,* 16, 356-360. doi: 10.1177/104365960527 8944

Giger. J. & Davidhizar, R. (2002). Culturally competent care: emphasis on understanding the people of Afghanistan, Afghanistan Americans, and Islamic culture and religion. International Nursing Review, 49, 79-86. Retrieved from CINAHL Full Text database.

Gocek, F., & Balaghi, Sh. (1994). *Reconstructing gender in the Middle East: Tradition, identity, and power.* New York: Columbia University Press.

Goldberg, L. (2002). Rethinking the birthing body: Cartesian dualism and perinatal nursing. *Journal of Advanced Nursing*, 37, 445-451. Retrieved from CINAHL Full Text database.

Goldberg, L. S. (2004). *The perinatal nursing relation: In search of a woman-centered experience.* (Doctoral dissertation). Canada, Alberta: University of Alberta.

Goldberg, L. S. (2005). Introductory engagement within the perinatal nursing relationship. *Nursing Ethics*, 12, 401-413. doi: 10.1191/0969733005ne804oa

Goldberg, L. S. (2008). Embodied trust within the perinatal nursing relationship. *Midwifery*, 24, 74–82. doi: 10.1016/j.midw.2006.11.003

Goldberg, L., Ryan, A., & Sawchyn, J. (2009). Feminist and queer phenomenology: a framework for perinatal nursing practice, research, and education for advancing lesbian health. *Journal of Health Care for Women International*, 30, 436-449. Retrieved from CINAHL database.

Goldberg, L., Harbin, A., & Campbell, S. (2011). Queering the birthing space: Phenomenological interpretations of the relationships between lesbian couples and perinatal nurses in the context of birthing care. *Sexualities*, 14, 173-192. Retrieved from CINAHL database.

Gordon, J., Sheppard, L., & Anaf, S. (2010). The patient experience in the emergency department: A systematic synthesis of qualitative research. *International Emergency Nursing,* 18, 80-88. doi: 10.1016/j.ienj.2009.05.004

Goubert, L., Craig, K.D., Vervoort, T., Morley, S., Sullivan, M.J., de C Williams, A.C., Cana, A. & Crombez, G. (2005) Facing others in pain: the effects of empathy. *Pain*, 118, 285–288.

Granger, K. (2013). Personal view: Healthcare staff must properly introduce themselves to patients. *British Medical Journal*, 13, 374. doi: 10.1136/bmj.f5833.

Greenwood, B. (2013). *Nursing skills for the emergency room*. Retrieved from http://woman.thenest.com/nursing-skills-emergency-room-1610.html

Groenewald, T. (2004). A phenomenological research design illustrated. International *Journal of Qualitative Methods*, 3, 1-26, Retrieved from http://www.ualberta.ca/~iiqm/backissues/3_1/html/groenewald.html

Grosz, E. (1994). *Volatile bodies: Toward a corporeal feminism*. Indianapolis, IN: Indiana University Press.

Gulam, H. (2003). Care of the Muslim patients. *Australian Nursing Journal*, 23-25. Retrieved from CINAHL Full Text database.

Guruge, S., Hunter, J., Barker, K., McNally, J., & Magalhaes, M. (2010). Immigrant women's experiences of receiving care in a mobile health clinic. *Journal of Advanced Nursing*, 66, 350-359. doi: 10.1111/j.1365.2648.2009.05182.x

Haideh, M. (2011). Islamic Feminism Revisited. *Comparative Studies of South Asia, Africa, & the Middle East*, 31, 76-84. doi:10.1215/1089201x-2010-054

Hall J.M. & Stevens P.E. (1991) Rigor in feminist research. *Advances in Nursing Science*, 13(3), 16–29. Retrieved from PubMed database.

Hamdan, A. (2009a). *Muslim women speak tapestry of lives and dreams.* Canada, Toronto: Women 's Press.

Hamdan, A. (2009b). Reflexivity of discomfort in insider-outsider educational research. *McGill Journal of Education*, 44, 377-404.

Hamington, M. (2004). *Embodied care: Jane Addams, Maurice Merleau-Ponty, and Feminist Ethics.* University of Illinois Press: Urbana & Chicago: United States.

Hammoud, M. M., White, C. B., & Fetters, M. D. (2005). Opening cultural doors: Providing culturally sensitive healthcare to Arab American and American Muslim patients. *American Journal of Obstetrics & Gynecology*, 193, 1307-1311. Retrieved from CINAHL with Full Text.

Hattar-Pollara, M. & Meleis, A. (1995). The Stress of immigration and the daily lived experiences of Jordanian immigrant women in the United States. West J Nurs Res, 17, 521-539. doi: 10.1177/019394599501700505

Heidegger, M. (2005). *Being and time* (M. N. Verlag, Trans.). Malden, US: Blackwell Publishing. (Original work published 1962).

Hitchcock, J., Schubert, Ph., & Thomas, S. (Eds.) (2010). *Community health nursing: Caring in action,* New York: Thomson Delmar Learning.

Higginbottom, G., Bell, A., Arsenault, J., Pillay, J. (2012). An integrative review of experiences of maternity services for immigrant women in Canada. *Diversity & Equality in Health & Care,* 9, 253-266. Retrieved from CINAHL with Full Text database.

Husserl, E. (2010). *The idea of phenomenology*. (L. Hardy, Trans.). MA, USA: Kluwer Academic Publishers. (Original work published 1964).

Immigration Watch Canada. (2010). *Canada - Permanent Residents, 1860 to 2010*. Retrieved from http://www.immigrationwatchcanada.org/

Jiwani, Y. (2001). *Intersecting inequalities: Immigrant women of colour, violence, and health care*. The Vancouver Foundation: Canada.

Jones, A. (1998). Some reflections on clinical supervision: An existential-phenomenological paradigm. *European Journal of Cancer Care*, 7, 56-62. Retrieved from CINAHL Full Text database.

Jones, A. (2001). Absurdity and being-in-itself. The third phase of phenomenology: Jean-Paul Sartre and existential psychoanalysis. *Journal of Psychiatric and Mental Health Nursing,* 8, 367-372. Retrieved from CINAHL with Full Text database.

Jones, Sh. (2008). Emergency nurses' caring experiences with Mexican American patients. *Journal of Emergency Nursing*, 34, 199-204. doi: 10.1016/j.jen.2007.05.009

Jones, Sh. (2012). *The development of trust in the nurse-patient relationship with hospitalized Mexican American patients*. Retrieved from ProQuest Dissertations & Theses database.

Jones, C. B., Sambrook, S., & Irvine, F. (2009). The phenomenological focus group (group interview): An oxymoron. *Journal of Advanced Nursing*, 65, 663-671. Retrieved from CINAHL with Full Text.

Kacperek, L. (1997). Clinical. Non-verbal communication: the importance of listening. *British Journal of Nursing*, 6, 275-279. Retrieved from CINAHL with Full Text.

Kai Tiaki Nursing New Zealand. (2010). 'Serious and system' problems in aged care. *Kai Tiaki Nursing New Zealand*, 16, 7. Retrieved from Nursing Reference Center.

Kanahara, Sh. (2006). A review of the definitions of stereotype and a proposal for a progressional model. *Individual Difference Research*, 4, 306-321. Retrieved from CINAHL with Full Text database.

Kaminski, J. (2009). Harnessing the wave of co-creation. *Online Journal of Nursing Informatics,* 13, 1-7. Retrieved from CINAHL Full Text database.

Keddy, B., Gregor, F., Foster, S., & Denney, D. (1999). Theorizing about nurses'work lives: The personal and professional aftermath living with health care reform. *Nursing Inquiry,* 6, 58-64. Retrieved from PubMed database.

Kelley, K. & Frinzi, Ch. (2011). Empathy and nursing education from mirror neurons to the experience of empathy: 21st century nursing education. *International Journal for Human Caring.*15, 22-28. Retrieved from CINAHL Full Text database.

Khalil, D. (2009). Nurses' attitude towards 'difficult' and 'good' patients in eight public hospitals. *Journal of International Nursing Practice*, 15, 437-443. doi:10.1111/j.1440-172X.2009.01771.x

Kihlgren, A., Nilsson, M., Skovdahi, K., Palmblad, B., & Wimo, A. (2004). Older patients awaiting emergency department treatment. *Scand J Caring Sci*, 18, 169–176. Retrieved from CINAHL Full Text database.

Kim-Godwin, Y. S., Alexander, J. W., Felton, G., Mackey, M. C., & Kasakoff, A. (2006). Prerequisites to providing culturally competent care to Mexican migrant farmworkers: a Delphi study. *Journal of Culture Divers*, 13(1), 27-33. Retrieved from CINHAL Full Text database.

Kincheloe, J. L., & McLaren, P. (2005). Rethinking critical theory and qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 301-312). Thousand Oaks, CA: Sage.

King, K. (1994). Method and methodology in feminist research: what is the difference? Reflexivity. *Journal of Advanced Nursing*, 20, 19-22. Retrieved from PubMed database.

Kirk, T. (2007). Beyond empathy: clinical intimacy in nursing practice. Nursing Philosophy, 8, 233-243. Retrieved from CINHAL Full Text database.

Kobayashi, K., Prus, S., & Lin, Z. (2008). *Ethnic differences in self-rated and functional health: Does immigrant status matter?* Retrieved from ProQuest Dissertations & Theses database.

Koch, T. (1995). Interpretive approaches in nursing research: The influence of Husserl and Heidegger. *Journal of Advanced Nursing*, 21, 827-836. Retrieved from PubMed database.

Korac-Kakabadse, N., Kouzmin, A., Korac-Kakabadse, A., & Savery, L. (2001). Low and high context communication patterns: Towards mapping cross cultural encounters. *Cross Cultural Management,* 8, 3-24. Retrieved from CINHAL Full Text database.

Kridli, S. A. (2002). Health beliefs and practices among Arab women. *The American Journal of Maternal/Child Nursing,* 27, 178-182. Retrieved from PubMed database.

Kridli, S. A., & Fakhouri, H. (2003). Health needs of Arab American women in Michigan. *Journal of Michigan Nurse*, 76, 9-14. Retrieved from CINAHL Full text database.

Kulwicki, A. D., Miller, J., & Schim, S. M. (2000). Collaborative partnership for culture care: Enhancing health services for the Arab community. *Journal of Transcultural Nursing,* 11 (1), 31-39. doi: 10.1177/104365960001100106

Kumas¸-Tan, Z., Beagan, B., Loppie, Ch., MacLeod, A., & Frank, B. (2007). Measures of cultural competence: Examining hidden assumptions. *Academic Medicine*, 82, 548-557. Retrieved from CINAHL Full Text database.

Lackner, L. (2009). *Culturally congruent nursing care: A phenomenological study of native American women with breast cancer.* Retrieved from ProQuest Dissertations & Theses database.

Lambert V, Keogh D (2014a) Health literacy and its importance for effective communication. Part 1. *Nursing Children and Young People*. 26, 3, 31-37. Retrieved from CINAHL Full Text database.

Lambert V, Keogh D (2014b) Health literacy and its importance for effective communication. Part 2. *Nursing Children and Young People*. 26, 4, 32-36. Retrieved from CINAHL Full Text database.

Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. International Journal of Qualitative Methods, 2, 21-35. Retrieved from http://ejournals.library.ualberta.ca/index.php/IJQM/article/view/4510/3647

Lee, T. Y., Landy, C. K., Wahoush, O., Khanlou, N, Liu, Y. Ch., & Li, Ch. (2014). A descriptive phenomenology study of newcomers' experience of maternity care services: Chinese women's perspectives. *Health Services Research*, 14, 114-122. Retrieved from CINAHL Full Text database.

Leininger, M. (1991). Transcultural nursing goals and challenges for 1991 and beyond. *Journal of Transcultural Nursing*, 2, 1-2. doi: 10.1177/104365969100200201

Leininger, M. (1996). Major directions for transcultural nursing: A Journey into the 21st Century. *Journal of Transcultural Nurisng*, 7 (2), 28-31.doi:10.1177/104365969600700206

Leininger, M. (1997). Overview of the theory of culture care with Ethnonursing research method. *Journal of Transcultural Nurisng*, 8, 32-52. doi: 10.1177/104365969700800205

Leininger, M. (1999). What is transcultural nursing and culturally competent care? *Journal of Transcultural Nursing*, 10 (1), 9. doi: 10.1177/104365969901000105

Leininger, M. M. & McFarland, M. R. (2006). *Culture Care Diversity and Universality: A worldwide nursing theory.* (2nd ed., pp 1-43). Sudbury, Ontario, Canada: Jones and Bartlett Publishers.

Lin, C., Hsu, M., & Chong, C. (2008). Differences between emergency patients and their doctors in the perception of physician empathy: Implications for medical education. *Education for Health: Change in Learning and Practice*, 21, 1-9.

Lin, Y. & Lin, C. (2011). Factors predicting patients' perception of privacy and satisfaction for emergency care. *Emergency Medicine Journal*, 28, 604-608. doi: 10.1136/emj.2010.093807.

Lopez, K., & Willis, D. (2004). Descriptive versus interpretive phenomenology: Their contribution to nursing knowledge. *Qualitative Health Research,* 14, 726-735. Retrieved from PubMed database.

Mackey, S. (2005). Phenomenological nursing research: Methodological insights derived from Heidegger's interpretive phenomenology. *International Journal of Nursing Studies,* 42, 179-186. Retrieved from PubMed database.

Main, C., McCallin, A., & Smith, N. (2006). Cultural safety and cultural competence: what does this mean for physiotherapists? *New Zealand Journal of Physiotherapy,* 34, 160-166. Retrieved from PubMed database.

Manchester, A. (2013). Cultural safety should be reviewed. *Kai Tiaki Nursing New Zealand,* 19, 14. Retrieved from PubMed database.

Marrone, S., R. (2008). Factors that influence critical care nurses' intentions to provide culturally congruent care to Arab Muslims. *Journal of Transcultural Nursing,* 19 (1), 8-15. doi: 10.1177/1043659607309143

Mayeroff, M. (2011). On Caring. International Journal of Human Caring, 15, 47-51.

McConnel, E. (1997). Patients, machines, and staff nurses. *Nursing Connections Journal*, 10, 5-11.

McDaniel, S., Beckman, H., Morse, D., Silberman, J., Seaburn, D., & Epstein, R. (2007). Physician self-disclosure in primary care visits. Enough about you? What about me? *Arch Intern Med*, 167, 1321-1326. Retrieved from CINAHL Full Text database.

McGilton, K., Boscart, V., Fox, M., Sidani, S., Rochon, E., & Sorin-Peters, R. (2009). A systematic review of the effectiveness of communication interventions for health care providers caring for patients in residential care settings. *Worldviews on Evidence-Based Nursing,* 6, 149-159. Retrieved from CINHAL Full Text database.

McKennis, A. (1999). Caring for the Islamic patient. *Association of Operating Room Nurses Journal*, 69, 1187-1196. Retrieved from CINAHL Full Text database.

McQueen, A. (2004). Emotional intelligence in nursing work. *Journal of Advanced Nursing*, 47, 101-108. doi: 10.1111/j.1365-2648.2004.03069.x

Merleau-Ponty, M. (1964). *The primacy of perception and other essays on phenomenological psychology, the philosophy of art, history and politics.* (J. M. Edie, Trans). Evanston, United States: Northwestern University Press.

Merleau-Ponty, M. (1968). *The visible and the invisible followed by working notes*. (A. Lingis, Trans). Evanston, United States: Northwestern University Press.

Merleau-Ponty, M. (2005). *Phenomenology of perception*. (S. Colin, Trans.). New York: Rutledge Classics. (Original work published 1958).

Merriam-Webster. (2014). In *Encyclopædia Britannica online*. Retrieved from http://www.merriam-webster.com/dictionary

Michaelsen, J. (2012). Emotional distance to so-called difficult patients. *Scandinavian Journal of Caring Sciences,* 26, 90-97. doi: 10.1111/j.1471-6712.2011.00908.x

Miller, Ch. (2002). *The foundation of patient communication - Part five*. Retrieved from http://www.charlydmiller.com/COMM/PtComm5.html.

Munoz and Luckmann (2005). *Transcultural communication in nursing*. (2nd ed.). New York: Thomson Delamar Learning.

Nath, R. & Craig, J. (1999). Practicing family therapy in India: How many people are there in a marital subsystem? *Journal of Family Therapy*, 21, 390-406. Retrieved from CINAHL Full Text database.

Ngwakongnwi, E., Hemmelgarn, B. R., Musto, R., Quan, H., & King-Shier, K. M. (2012). Experiences of French speaking immigrants and non-immigrants accessing health care services in a large Canadian city. *Int J Environ Res Public Health.*, 9, 3755-3768. doi: 10.3390/ijerph9103755.

Nordby, H. (2007). Meaning and normativity in nurse-patient interaction. *Nursing Philosophy*, 8, 16-27. Retrieved from CINAHL Full Text database.

Nova Scotia Department of Health. (2005). *A Cultural Competence Guide for Primary Health Care Professionals in Nova Scotia.* Retrieved from http://healthteamnovascotia.ca/cultural_competence/Cultural_Competence_guide_for_Primary_Health_Care_Professionals.pdf

Nyden, K., Petersson, M., & Nystrom, M. (2003). Unsatisfied basic needs of older patients in emergency care environments – challenges to an active role in decision making. *Journal of Critical Nursing*, 12, 268-274. Retrieved from CINAHL Full Text database.

Olsen, D., Dixon, J., Grey, M., Deshefy-Longhi, T., & Demarest, J. (2005). Privacy concerns of patients and nurse practitioners in primary care -- an APRNet study. *Journal of The American Academy of Nurse Practitioners*, 17, 527-534. Retrieved from CINAHL Full Text database.

O'Mahony, J., & Donnelly, T. (2007). The influence of culture on immigrant women's mental health care experiences from a health care provider's perspective. *Issues in Mental Health Nursing*, *28*(5), 453–471.

O'Mahony, J., & Donnelly, T. (2010). A postcolonial feminist perspective inquiry into immigrant women's mental health care experiences. *Issues in Mental Health Nursing*, 31, 440–449. doi: 10.3109/01612840903521971

Ott, B., Al-Khadhuri, J., & Al-Junaibi, S. (2003). Preventing ethical dilemmas: Understanding Islamic health care practices. *Pediatric Nursing*, 29, 227- 230. Retrieved from CINAHL Full Text database.

Oxford Dictionary Language Matters. (2014). In *Oxford University Press*. Retrieved from http://www.oxforddictionaries.com/definition/english/respect?q=respect

Papadopoulos, I., & Omeri, A. (2008). Transcultural Nursing theory and models: The challenges of application. *Contemporary Nurse*, 28, 45-47. Retrieved from PubMed database.

Patton, M. Q. (2002a). Purposeful sampling. In *Qualitative research & evaluation methods*, (3rd ed., pp. 230-248).Thousand Oaks, CA: Sage.

Patton, M. Q. (2002b). Qualitative interviewing. *Qualitative research & evaluation methods*, (3rd ed., pp. 339-418). Thousand Oaks, CA: Sage.

Perry P.A. (1994) Feminist empiricism as a method for inquiry in nursing. *Western Journal of Nursing Research*, 16, 480–494. Retrieved from PubMed database.

Poortinga, W., & Pidgeon, N. (2003). Exploring the dimensionality of trust in risk regulation. *Risk analysis*, 23, 961–973. Retrieved from CINAHL Full Text database.

Potter, P. A. & Perry, A. G. (2005). *Fundamentals of nursing*. St. Louis: Elsevier Mosby.

Prinz, R. J., & Miller, G. E. (1994). Family-based treatment for childhood antisocial behavior: Experimental influences on dropout and engagement. *Journal of Consulting and Clinical Psychology*, 62, 645–650. Retrieved from Ovid.

Purnell, L. (2002). The Purnell model for cultural competence. *Journal of Transcultural Nursing*, 13, 193-196. Retrieved from CINAHL Full Text database.

Qin, D. (2000). *Crossing borders: International women students in American higher education.* Retrieved from ProQuest Dissertations & Theses database.

Ramadan, T. (2004). *Western women and the future of Islam*. Retrieved from http://www.dal.worldcat.org.ezproxy.library.dal.ca/title/western-muslims-and-the-future-of-islam/oclc/300406445&referer=brief_results

Ryan, A. (2007). *Wise women: A phenomenological study of nurse-to-nurse mentoring in perinatal care*. Retrieved from ProQuest Dissertations & Theses database.

Ryan, A., Goldberg, L., & Evans, J. (2010). Wise women: mentoring as relational learning in perinatal nursing practice. *Journal of Clinical Nursing*, 19, 183-191. doi: 10.1111/j.1365-2702.2009.02852.x

Routledge, F. (2007). Exploring the use of feminist philosophy within nursing research to enhance post-positivist methodologies in the study of cardiovascular health. *Journal of Advanced Nursing,* 8, 278-290. Retrieved from CINAHL Full Text database.

Salmon, D. (1999). A feminist analysis of women's experiences of perineal trauma in the immediate post-delivery period. *Midwifery*, 15, 247-256. Retrieved from PubMed database.

Sanmartin, C., Berthelot, J., Murphy, E., Blackwell, D., Gentleman, J., Martinez, M., & Simile, C. (2006). Comparing health and health care use in Canada and the United States. *Health Affairs*, 25, 1133-1142. doi:10.1377/hlthaff.25.4.1133

Sarkisian, N., Gerena, M., & Gerstel, N. (2006). Extended family ties among Mexicans, Puerto Ricans, and whites: Super-integration or disintegration? *Family Relations*, 55, 331-344, Retrieved from Jstor database.

Sartre, J. P. (1973). *Existentialism and Humanism*. London: Eyre Methuen. (Original work published 1948).

Schub, T. (2012). *Quick lesson about iron deficiency anemia*. Retrieved from CINAHL Full Text database.

Scott, PA., Taylor, A., Välimäki, M., Leino-Kilpi, H., Dassen, T., Gasull, M., … Arndt, M. (2003). Clinical practice. Autonomy, privacy and informed consent 2: postnatal perspective. *British Journal of Nursing*, 12, 117-127. Retrieved from CINAHL Full Text database.

Seibold, C. (2000). Qualitative research from a feminist perspective in the postmodern era: Methodological, ethical, and reflective concerns. *Nursing Inquiry Journal*, 7, 147-155. Retrieved from CINAHL Full Text database.

Seifert, P., C. (2008). The ANA code of ethics and AORN's explications. *Perioperative Nursing Clinics Journal,* 3, 183-189. doi: 10.1016/j.cpen.2008.04.012

Son, G., & Kim, H. (2006). Culturally familiar environment among Immigrant Korean elders. *Research and Theory for Nursing Practice: An international Journal,* 20, 159-171. Retrieved from CINAHL Full Text database.

Srivastava, R. (Ed.). (2007). *The healthcare professional's guide to clinical cultural competence.* ON: Mosby Elsevier.

Statistics Canada (2006). *Single and multiple ethnic origin responses.* Retrieved November 1, 2011, from http://www12.statcan.gc.ca/census-recensement/2006/dp-pd/tbt/Rp-eng.cfm?LANG=E&APATH=3&DETAIL=0&DIM=0&FL=A&FREE=0&GC=0&GID=0&GK=0&GRP=1&PID=92333&PRID=0&PTYPE=88971%2c97154&S=0&SHOWALL=0&SUB=801&Temporal=2006&THEME=80&VID=0&VNAMEE=&VNAMEF

Statistics Canada (2011). *Single and multiple ethnic origin responses.* Retrieved December 21st, 2013, from http://www12.statcan.gc.ca/census-recensement/2011/dp-pd/tbt-tt/Rp-eng.cfm?TABID=1&LANG=E&APATH=3&DETAIL=0&DIM=0&FL=A&FREE=0&GC=0&GK=0&GRP=1&PID=103251&PRID=0&PTYPE=101955&S=0&SHOWALL=0&SUB=0&Temporal=2011&THEME=90&VID=0&VNAMEE=&VNAMEF

Staudt, M., Lodato, G., & Hickman, C. R. (2012). Therapists Talk About the Engagement Process. *Community Mental Health Journal*, 48, 212–218. Doi: 1 0.1007/s10597-011-9377-x

Steck, M. (2012). Concept analysis: Awareness of discrimination based on genetics information. *Nursing Forum: An Independent Voice for Nursing*, 47, 100-105. Retrieved from CINAHL Full Text database.

Stewart, M., Schiavo, R. S., Herzog, D. B., and Franko, D. L. (2008). Stereotype, prejudice, and discrimination of women with anorexia nervosa. *European Eating Disorders Review*, 16, 311-318. Retrieved from CINAHL Full Text database.

Stuart, P., Parker, S., & Rogers, M. (2003). Giving a voice to the community: A qualitative study of consumer expectations for the emergency department. *Emergency Medicine*, 15, 369-375. Retrieved from CINAHL Full Text database.

Stulik, A. (1985). *An Adaptation of the culturological assessment tool for the health care provider working with Arab Americans.*

Thomas, S. (2005). Through the lens of Merleau-Ponty: Advancing the phenomenological approach to nursing research. *Nursing Philosophy*, 6, 63–76. Retrieved from CINAHL Full Text database.

Thompson, D., & Yarnold, P. (1995). Relating patient satisfaction to waiting time perceptions and expectations: The disconfirmation paradigm. *Academic Emergency Medicine*, 2, 1057-1062.

Tran, T., Schutte, W., Muelleman, R., & Wadman, M. (2002). Provision of clinically based information improves patients' perceived length of stay and satisfaction with EP. *American Journal of Emergency Medicine*, 20, 506-509. doi: 10.1053.ajem/2002.36252.

Tryon, G. S., & Winograd, G. (2002). *Goal consensus and collaboration. In J. C. Norcross (Ed.), Psychotherapy relationships that work: Therapist contributions to patients.* New York: Oxford.

Tsai, H., Tsai, Y., Weng, L., & Chou, H. (2013). More than communication skills: experiences of communication conflict in nursing home nurses. *Medical Education*, 47, 990-1000. doi: 10.1111/medu.12233

Van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy.* State University of New York Press: United States.

Van Manen, M. (1997). From meaning to method. *Qualitative Health Research*, 7, 345-369. Retrieved from CINAHL Full Text database.

Vidyasagar, G. & Rea, D. (2004). Saudi women doctors: Gender and careers within Wahhabic Islam and a "Westernised' work culture. Women's Studies International Forum, 27, 261-280.

Vouzavali, F., Papathanassoglou, E., Karanikola, M., Koutroubas, A., Patiraki, E., & Papadatou, D. (2011). 'The patient is my space': Hermeneutic investigation of the nurse-patient relationship in critical care. *Journal of Nursing in Critical Care,* 16, 140-151. Retrieved from CINAHL Full Text database.

Wall S. (2007). Globalization makes new demands on public health research. *Scandinavian Journal of Public Health*, 35, 449–453. Retrieved from CINAHL Full Text database.

Walsh, K. (2009). *Disciplined silence: a focused ethnography of exemplary emergency nursing practice.* Retrieved from ProQuest Dissertations & Theses database.

Walters, A. J. (1995). The phenomenological movement: Implications for nursing research. *Journal of Advanced Nursing*, 22, 791-799. Retrieved from PubMed database.

Wang, Q. (2011). *Doctor-patient communication and patient satisfaction: A cross-cultural comparative study between China and the U.S*. Retrieved from ProQuest Dissertations & Theses database.

Wanzer, M., Booth-Butterfield, M., & Gurber, K. (2004). Perceptions of health care providers' communication: Relationships between patient-centered communication and satisfaction. *Health Communication*, 16, 363-383.

Warda, M. R. (2000). Mexican Americans' perceptions of culturally competent care. *Western Journal of Nursing Research*, 22(2), 203-224. doi: 10.1177/01939450022044368

Wath, A., Wyk, N., & Rensburg, E. (2013). Emergency nurses' experiences of caring for survivors of intimate partner violence. *Journal of Advanced Nursing*, 69, 2242-2252. doi: 10.1111/jan.12099

Watson, J. (1987). *Postmodern nursing and beyond.* Churchill Livingstone

Watson, W., Marshall, E., & Fosbinder, D. (1999). Elderly patients' perceptions of care in the emergency department. *Journal of Emergency Nursing*, 25, 88-92. Retrieved from CINAHL Full Text database.

Watson Caring Science Institute. (2010). *Core concepts of Jean Watson's theory of human caring/caring science.* Retrieved from http://www.google.com.sa/url?url=http://watsoncaringscience.org/files/Cohort%25206/watsons-theory-of-human-caring-core-concepts-and-evolution-to-caritas-processes-handout.pdf&rct=j&frm=1&q=&esrc=s&sa=U&ei=HsjLU_zoGePF7AbBoYHoBQ&ved=0CBcQFjAA&usg=AFQjCNEHDpQCrUenNWU2vLF3IX24HhD9qQ

Weiss, Gail. (1999). *Body images: Embodiment as intercorporeality*. Retrieved from http://lib.myilibrary.com.ezproxy.library.dal.ca/Open.aspx?id=518001

Wikberg, A., & Eriksson, K., (2007). Intercultural caring: An abductive model. *Scandinavian Journal of Caring Science,* 22, 485-496. doi: 10.1111/j.1471-6712.2007.00555.

Wilde, M. (1999). Why embodiment now? *Advances in Nursing Science,* 22, 25-38. Retrieved from http://journals.lww.com/advancesinnursingscience/fulltext/1999/12000/why_embodiment_now_.4.aspx

Williams, R. (2008). *Tokens of trust*. London: Canterbury Press Norwich.

Woogara, J. (2001). Human rights and patients' privacy in UK hospitals. *Nursing Ethics,* 8, 243-246. Retrieved from CINAHL Full Text database.

Wolf, L. & Delao, A. (2013). Identifying the educational needs of emergency nurses in rural and critical access hospitals. *The Journal of Continuing Education in Nursing*, 44, 424-428. doi: 10.3928/00220124-20130816-38

Wuest, J. (1994). Professionalism and the evolution of nursing as a discipline: A feminist perspective. In Cody, W. K. (Eds.), *Philosophical and theoretical perspective for advanced nursing practice* (pp. 85-97). Sudbury, Ontario, Canada: Jones and Bartlett Publisher.

Yatchmenoff. (2005). Measuring client engagement from the client's perspective in nonvoluntary child protective services. *Journal of Research on Social Work Practice*, 15, 84-96. Retrieved from CINAHL Full Text database.

Young, A. & Flowers, L. (2001). Patients as partners, patients as problem solvers. *Health Communication*, 14, 69-97.

Yount, K. M. (2005). Women’s family power and gender preference in Minya, Egypt. *Journal of Marriage and Family,* 67, 410-428. Retrieved from JSTOR database.

Yousef, A. O. (2008). Health beliefs, practice, and priorities for health care of Arab Muslims in the United States: Implications for nursing care. *Journal of Transcultural Nursing,* 19, 284-291. doi: 10.1177/1043659608317450

Zavertnik, J. E., Huff, T. A., MSN, & Munro, C. L. (2010). Innovative approach to teaching communication skills to nursing students. *Journal of Nursing Education,* 49, 65-71. Doi: 10.3928/01484834-20090918-06

Appendix A

Interviews Questions Guide

DALHOUSIE
UNIVERSITY
Inspiring Minds

Interviews Questions Guide

I am interested in the experiences of Arab immigrant women in EDs in HRM.

1) Please describe your first experience in EDs in HRM?

(Probes: When did you go? Who accompanied you? How did you feel emotionally?)

2) Describe your interactions with health care providers and staff during your first ED experience?

(Probes: Nurses, Physicians, Paramedics, Support Staff).

3) What have you found to be supportive during your first visit to EDs in HRM?

(Probes: Were you greeted? Atmosphere? Guidance? where to go? Interpreters? Health care providers? Education? Materials: English/Arabic? Cultural needs? Gender of providers?)

4) What are the challenges you encountered when visiting EDs in HRM for the first time?

(Probes: Were you greeted? Atmosphere? Guidance? Providers? Education? Language? Cultural needs/sensitivity? Interpreters?)

5) What modifications or changes would you like to be incorporated in EDs in HRM?

   (Probes: Physical setup/workshops on cultural education for providers/ health education materials in Arabic/ more translators?).

6) How do you think these modifications could be implemented?

   (Probes: Support from policy makers, involvement of Arabic health care providers and/or interpreters, etc…).

7) How do you think these modifications could further enhance/empower your experiences as an Arab immigrant woman in EDs?

   (Probes: cultural awareness/ implications/ education/ discrimination/ stereotyping)

8) Is there anything else you would like to share today?

Appendix B

Screening Questionnaires

Screening Questionnaires

1) As you know I am seeking participants who are within the age range 19 to 50 years old. What is your age range? ____ 19-25, ____ 26-35, ____ 36-50

   (This question will be asked to determine participants' eligibility and to select women from different age groups in order for the sample to address experiences of diverse Arab immigrant women who have visited EDs).

2) I am looking for diverse population that can enrich the study. What is your nationality?_________

   (Participants will be selected from as many different countries as possible in an attempt to make the sample reflective of the diversity of the Arab community).

3) What is your country of origin? The country where you were raised? ___________

   (This question will ensure that participants meet the eligibility criteria of being raised in an Arabic country).

4) What is your religion/world view? __________

   (This question will be asked to include Arab immigrant women with different religious orientation).

5) What is your first language? __________

   (This question will be asked to ensure eligibility criteria: being Arabic speaking).

6) Was your first visit to any ED in HRM more than two years? Were you a patient during the visit? _________

   (This question will be asked for eligibility purpose: to exclude patients whose first visit more than 2 years or to exclude those whose first visit was to accompany a patient).

7) What is you partnership status? ____________

   (This question will be asked to include women who have spouses and ones who do not in order to examine the effect of the partner in their experiences).

8) Do you have any children? How many? ______________

   (This question will be asked to include women who have children and ones who do not in order to examine the effect of having children in their experiences and to see if the number of children influences their experiences).

Appendix C

Participants' Demographic Data

Name	Age Range	Nationality	Religion	Marital Status	Number of Children	Profession	Level of Education
Doaa	19-25	Saudi	Islam	Married	0	Student at Dalhousie (ESL*)	Bachelor
Nada	26-35	Saudi	Islam	Single	0	Student at Dalhousie (Physics)	Masters
Iman	26-35	United Arab Emirates	Islam	Married	0	Student at Dalhousie (Physics)	Masters
Safa	26-35	Saudi	Islam	Married	0	Student at Dalhousie (Math)	Masters
Rogaiah	36-50	Yemen	Islam	Married	3	Journalist and Kids' Teacher	Bachelor
Meriam	36-50	Saudi	Islam	Married	4	Registered Nurse	PhD**

* Ages in Range to Protect Anonymity

*ESL: English as a Second Language

*PhD: Doctorate of Philosophy

Appendix D

Letter from The Imam of Islamic Association of Nova Scotia

Islamic Association of Nova Scotia (IANS) Dartmouth Masjid

May 11, 2013

Research Ethics
6299 South Street, Suite 231
Halifax, NS
B3H 4H6

TO WHOM IT MAY CONCERN,
This is a letter of support for Amel AlGallaf, who is a student doing her master's thesis in "experiences of Arab immigrant women in emergency departments in Halifax Regional Municipality." Arrangement will be made with her to present the purpose of her study and to give an overview of the nature of the study in the IANS Dartmouth Masjid with some Arab immigrant women.

Sincerely,

Immam. Hamzah Mangera

Shaikh of IANS Dartmouth Masjid

IANS Dartmouth Masjid. 42 Leaman Drive, Dartmouth -Nova Scotia
B3A 2K9 | Tel: (902) 469-9490

Appendix E

Recruitment Advertisement (Text-Based)

DALHOUSIE UNIVERSITY
Inspiring Minds

Invitation to Participate

What was your experience as an Arab immigrant woman of your first visit to an emergency department in HRM?

If you are an Arabic-speaking woman between 19 and 50 years old, you may be eligible to participate in a research study that explores the stories of Arab immigrant women accessing the Canadian health care system through Emergency Departments in Halifax Regional Municipality. I am, the principal investigator, a master's student at Dalhousie University, School of Nursing, and this study is part of my Master's thesis.

I am currently seeking Arab immigrant women to participate in a one-on-one interview lasting 60-90 minutes long and one group interview. If you may be interested in talking with me and sharing your story, please contact me for more information:

Amel AlGallaf at 902-412-6544
or via e-mail at am496038@dal.ca

Thesis Supervisor:
Dr. Lisa Goldberg, Dalhousie University, School of Nursing,
Lisa.Goldberg@dal.ca, Telephone # (902) 494-2988

Appendix F

Telephone Script

Hello. This is Amel AlGallaf, the principal investigator for a study titled “Experiences of Arab Immigrant Women in Emergency Departments in HRM.”

I would like to provide you with more information about the study. This study is aiming at better understanding experiences of Arab immigrant women who visited any ED in HRM for the first time within the last two years. Right now, I am recruiting participants for interviews and a group interview. One interview will be conducted in a date, time and location that is convenient for you and will last for 60 to 90 minutes. I will be the interviewer. A group interview will follow at a time and date that is mutually selected by interested participants and will last also for an hour and a half. Your age must be in the range between 19 and 50, and your first language must be Arabic. Do you have any question? [If yes, respond to the questions; if no, would you still be interested in participating? [If no, thank her for her time and end call; if yes, continue]

I am looking for a diverse population that could enrich the study. As a result, I would like to ask you some demographic questions to see if you can be included in the study. If you cannot be included in the study, your information will be destroyed right away after the call. Are you willing to continue? [If yes, continue with the screening questionnaires (Appendix B); if no, thank her for her time and end call].

Appendix G

Email Script

Hello. I received your email expressing your interest in participating in the study "Experiences of Arab Immigrant Women in Emergency Departments in HRM.".

I would like to provide you with more information about the study. This study is aiming at better understanding experiences of Arab immigrant women who visited any ED in HRM for the first time within the last two years. Right now, I am recruiting participants for interviews and a group interview. One interview will be conducted in a date, time and location that is convenient for you and will last for 60 to 90 minutes. I will be the interviewer. A group interview will follow at a time and date that is mutually selected by interested participants and will last also for an hour and a half. Your age must be in the range between 19 and 50, and your first language must be Arabic.

I am looking for a diverse population that could enrich the study. As a result, I would like to ask you some demographic questions to see if you can be included in the study. If you cannot be included in the study, your information will be destroyed right away after receiving your email.

The demographic questions:

1) As you know I am seeking participants who are within the age range 19 to 50 years old. What is your age range? ____ 19-25, ____ 26-35, ____ 36-50

2) I am looking for diverse population that can enrich the study. What is your nationality? _________

3) What is your country of origin? The country where you raised? ___________

4) What is your religion/world view? __________

5) What is your first language? __________

6) Was your first visit to any ED in HRM more than two years? Were you a patient during the visit? _________

7) What is you partnership status? ____________

8) Do you have any children? How many? ______________

If you have any question, feel free to contact me or email me at any time.

If you are interested in participating in the study, please answer the above questions and send them back to me.

Thank you very much for your time.

Amel AlGallaf, School of Nursing, Dalhousie University address: 616-3330 Barnstead Lane Halifax NS, Canada, B3L 0B1, am496038@dal.ca, telephone # (902) 412-6544

Appendix H

Interview Consent Form

Interview Consent Form

STUDY TITLE: Experiences of Arab Immigrant Women in Emergency Departments in Halifax Regional Municipality

PRINCIPAL INVESTIGATOR (PI):

Amel AlGallaf, School of Nursing, Dalhousie University address: 616-3330 Barnstead Lane Halifax NS, Canada, B3L 0B1, am496038@dal.ca, telephone # (902) 412-6544

SUPERVISOR: Dr. Lisa Goldberg. School of Nursing, Dalhousie University,
5869 University Avenue, PO Box 15000 Halifax, NS B3H 4R2
Lisa.Goldberg@dal.ca, telephone # (902) 494-2988

1. Introduction

You have been invited to participate in a research study being conducted by Amel AlGallaf who is a graduate student at Dalhousie University, as part of her masters in nursing program. Your participation in this study is voluntary and you may withdraw from the study at any time. The quality of your health care will not be affected by whether or not you withdraw from the study. The study is described below. This description tells you about the risks, and benefits, as well as any potential discomfort that you might experience. Participating in the study might not benefit you, but we might learn things that will benefit others. You should discuss any questions you have about this study with Amel AlGallaf.

2. The Purpose of the Study

The purpose of this research is to learn more about experiences of Arab immigrant women during their first visit to Emergency Departments (EDs) in Halifax Regional Municipality (HRM). Your experiences may include your needs, challenges, and interactions with health care providers.

3. Study Design

Six to eight Arab immigrant women will participate in one interview with the principal investigator.

4. Who can Participate in the Study

Any Arab immigrant woman who is between 19 and 50 years old, speaks Arabic as her primary language, has any religious orientation, has the mental and physical capacity to sign the informed consent, and visited any ED in HRM for the first time within the last two years is a possible candidate to be included in this study. If you speak a language other than Arabic as your first language or were raised in a country other than an Arabic-speaking country, you are not eligible to take part in this study.

5. Who will be Conducting the Research

Amel AlGallaf is the principal investigator (PI) in this research who will lead the research. Dr. Lisa Goldberg is a professor in the School of Nursing at Dalhousie University and the supervisor of this study. Dr. Anrea Chircop, is a professor at Dalhousie University and Dr. Amani Hamdan, a professor at Dammam University, Saudi Arabia, are also part of the research committee team. If you agree to participate, you will be interviewed by Amel AlGallaf, the PI.

6. What You will be Asked to Do

If you take part in this study, you will be interviewed once on a date, time and location convenient for you. You will be asked about your experiences when visiting any emergency department for the first time in HRM. The interview will take 60 to 90 minutes.

The interview will be audio taped, if you consent, and typed later. If you agree to participate in the study, anonymous quotes will be used in the publication of this research study.

7. Possible Risks and Discomforts

There are no physical risks associated with participating in this study. However, you may feel uncomfortable disclosing some of your sensitive issues. You can choose not to answer any question that makes you feel uncomfortable.

8. Possible Benefits

This study will not benefit you directly, but it will help in better understanding of Arab immigrant women’s experiences when visiting emergency departments in HRM. Bringing Arab immigrant women’s experiences and needs to the attention of health care providers may further assist them in providing safe, ethical, competent, and equitable care. The research also provides a basis for future studies concerning Arab immigrant women, which in tandem with additional research, may contribute to institutional policy development, to best practice guidelines, educational curricula, and continuing education for health care providers caring for Arab immigrant women, which in turn may result in a better quality of life for Arab immigrant women.

9. Compensation/Reimbursement

No compensation will be given.

10. Confidentiality and Anonymity

Anonymity

The collected data will be given to a transcriptionist. The transcriptionist will be asked to hide your identity, and pseudonyms will be used whenever a quote and/or experience will be included in the study. Your name and contact information will be kept in a secure locked cabinet in the PI's home office, and it will not be shared with others. Your name will not appear in any report or article published as a result of this study.

Confidentiality

The principal investigator will collect and use only the information needed to complete the study. This information will only be used for the purposes of this study. This information will include your:

- age
- nationality
- first language
- country of origin
- religion/world view
- partnership status
- parenting (how many children you have)

- information from the study interviews

The audio-tapes will be kept in a locked cabinet if not in use and destroyed after they are transcribed. The signed consent forms will be kept in separate locked storage. The laptop that will be used for analysis will also be kept in a locked cabinet and will be password protected, as well as the transcript data. All the audio-tapes, the signed consent forms, the data, the laptop, and the transcript data will be kept in my home office and the door will be locked when the data is not in use. The principal investigator, Amel AlGallaf, is the person responsible for keeping it secure.

The audiotapes that are in Arabic will be given to a translator in order to translate them into English. All the audiotapes will be given to a transcriptionist. Both the translator and the transcriptionist will be asked to sign a confidentiality form to reduce the risk for breach of confidentiality.

11. Questions

For further information about the study call Amel AlGallaf. Amel AlGallaf is the principal investigator. Her telephone number is (902) 412-6544. You can also contact the thesis supervisor, Dr. Goldberg. Her telephone number is (902) 494-2988.

12. New Information

It is possible (but unlikely) that new information may become available while you are in the study that might affect your health, welfare, or willingness to stay in the study. If this happens, you will be informed in a timely manner and will be asked whether you wish to continue taking part in the study or not.

13. Your Rights

You can stop the interview at any time, take breaks, or choose to not answer any question. If you change your mind during the interview and decide not to complete it, you can withdraw at anytime. If you want to withdraw, please inform the PI. All data collected up to the date you withdraw your consent, will remain in the study records, to be included in study related analyses unless you indicated no data to be included. After you have signed this consent form, you will be given a copy. At the end of this study, the result will be discussed with participants, if interested. A copy of any related published article will also be given to any participant interested.

14. Concerns or Problems?

If you have any difficulties with, or wish to voice concern about, any aspect of your participation in this study, you may contact Catherine Connors, Director of Dalhousie University's Office of Human Research Ethics Administration, for assistance at (902) 494-1462.

In the next part you will be asked if you agree (consent) to join this study. If the answer is "yes", you will need to sign the form.

15. Consent Form Signature Page

I have reviewed all of the information in this consent form related to the study called:

Experiences of Arab Immigrant Women in Emergency Departments in Halifax Regional Municipality

I have been given the opportunity to discuss this study. All of my questions have been answered to my satisfaction.

This signature on this consent form means that I agree to take part in this study and to include anonymous quotes from my interview in any publications and presentations from this study.

I understand that I am free to withdraw at any time.

________________ ______________________ _____ / ______ / ____
Signature of Participant Name (Printed) Year Month Day*

__________________ ____________________ _____ / ______ / ____
Signature of Investigator Name (Printed) Year Month Day*

I consent to having the interview recorded.

___________________ ______________________ _____/ _____/_____
Participant's Signature Name (Printed) Year Month Day*

_____ I would like to receive a summary of the final results and a copy of any publication related to this study.

Contact Information

____

____

____

***Note: Please fill in the dates personally**

I Will Be Given A Signed Copy Of This Consent Form

Thank you for your time and patience!

Appendix I

Group Interview Consent Form

Group Interview Consent Form

STUDY TITLE: Experiences of Arab Immigrant Women in Emergency Departments in Halifax Regional Municipality

PRINCIPAL INVESTIGATOR (PI):
Amel AlGallaf, School of Nursing, Dalhousie University address: 616-3330 Barnstead Lane Halifax NS, Canada, B3L 0B1, am496038@dal.ca, telephone # (902) 412-6544

SUPERVISOR: Dr. Lisa Goldberg. School of Nursing, Dalhousie University,
5869 University Avenue, PO Box 15000 Halifax, NS B3H 4R2
Lisa.Goldberg@dal.ca, telephone # (902) 494-2988

1. Introduction

You have been invited to participate in a research study being conducted by Amel AlGallaf who is a graduate student at Dalhousie University, as part of her masters in nursing program. Your participation in this study is voluntary and you may withdraw from the study at any time. The quality of your health care will not be affected by whether or not you withdraw from the study. The study is described below. This description tells you about the risks, and benefits, as well as any potential discomfort that you might experience. Participating in the study might not benefit you, but we might learn things that will benefit others. You should discuss any questions you have about this study with Amel AlGallaf.

2. The Purpose of the Study

The purpose of this research is to learn more about the experiences of Arab immigrant women during their first visit to Emergency Departments (EDs) in Halifax Regional Municipality (HRM). Your experiences may include your needs, challenges, and interactions with health care providers.

3. Study Design

You will participate in one group interview facilitated by the principal investigator.

4. Who can Participate in the Study

Any Arab immigrant woman who is between 19 and 50 years old, speaks Arabic as her primary language, has any religious orientation, has the mental and physical capacity to sign the informed consent, and visited any ED in HRM for the first time within the last two years is a possible candidate to be included in this study. If you speak a language other than Arabic as your first language or were raised in a country other than an Arabic-speaking country, you are not eligible to take part in this study.

5. Who will be Conducting the Research

Amel AlGallaf is the principal investigator (PI) in this research who will lead the research. Dr. Lisa Goldberg is a professor in the School of Nursing at Dalhousie University and the supervisor of this study. Dr. Anrea Chircop, is a professor at Dalhousie University and Dr. Amani Hamdan, a professor at Dammam University, Saudi Arabia, are also part of the research committee team. If you agree to participate, you will join a group interview facilitated by Amel AlGallaf, the PI.

6. What You will be Asked to Do

If you take part in this study, you will be asked to attend a group interview for 60 to 90 minutes. You will be discussing your experiences when visiting any emergency department for the first time in HRM. Keep all the shared information in the group interview confidential. However, participants may still disclose some of the information discussed in the group interview to someone else. Thus, confidentiality cannot be guaranteed.

The group interview will be audio taped and typed later. Anonymous quotes will be used in the publication of this research study.

7. Possible Risks and Discomforts

There are no physical risks associated with participating in this study. However, you may feel uncomfortable disclosing some of your sensitive issues. You can choose not to answer any question that makes you feel uncomfortable.

8. Possible Benefits

This study will not benefit you directly, but it will help in better understanding of Arab immigrant women’s experiences when visiting emergency departments in HRM. Bringing Arab immigrant women’s experiences and needs to the attention of health care providers may further assist them in providing safe, ethical, competent, and equitable care. The research also provides a basis for future studies concerning Arab immigrant women, which in tandem with additional research, may contribute to institutional policy development, to best practice guidelines, educational curricula, and continuing education for health care providers caring for Arab immigrant women, which in turn may result in a better quality of life for Arab immigrant women.

9. Compensation/Reimbursement

No compensation will be given.

10. Confidentiality and Anonymity

Anonymity

The collected data will be given to a transcriptionist. The transcriptionist will be asked to hide your identity, and pseudonyms will be used whenever a quote and/or experience will be included in the study. Your name and contact information will be kept in a secure locked cabinet in the PI home office. It will not be shared with others. Your name will not appear in any report or article published as a result of this study.

Confidentiality

The principal investigator will collect and use only the information needed to complete the study. This information will only be used for the purposes of this study. This information will include your:

- age
- nationality
- first language
- country of origin
- religion/world view
- partnership status
- parenting (how many children you have)

- information from the study group interview.

The audio-tape will be kept in a locked cabinet if not in use and destroyed after it is transcribed. The signed consent forms will be kept in separate locked storage. The laptop that will be used for analysis will also be kept in a locked cabinet and will be password protected, as well as the transcript data. The audio-tape, the signed consent forms, the data, the laptop, and the transcript data will be kept in my home office and the door will be locked when the data is not in use. The principal investigator, Amel AlGallaf, is the person responsible for keeping it secure.

The audiotape will be given to a translator in order to translate it into English. Then the audiotape will be given to a transcriptionist. Both the translator and the transcriptionist will be asked to sign a confidentiality form to reduce the risk for breach of confidentiality.

11. Questions

For further information about the study call Amel AlGallaf. Amel AlGallaf is the principal investigator. Her telephone number is (902) 412-6544. You can also contact the thesis supervisor, Dr. Goldberg. Her telephone number is (902) 494-2988.

12. New Information

It is possible (but unlikely) that new information may become available while you are in the study that might affect your health, welfare, or willingness to stay in the study. If this happens, you will be informed in a timely manner and will be asked whether you wish to continue taking part in the study or not.

13. Your Rights

You can take breaks, or choose to not answer any question. If you change your mind during the group interview and decide to leave the group interview, you can withdraw at anytime. If you want to withdraw, please inform the PI. All data collected up to the date you withdraw your consent, will remain in the study records, to be included in study related analyses unless you indicated no data to be included. After you have signed this consent form, you will be given a copy. At the end of this study, the result will be discussed with participants, if interested. A copy of any related published article will also be given to interested.

14. Concerns or Problems?

If you have any difficulties with, or wish to voice concern about, any aspect of your participation in this study, you may contact Catherine Connors, Director of Dalhousie University's Office of Human Research Ethics Administration, for assistance at (902) 494-1462.

In the next part you will be asked if you agree (consent) to join this study. If the answer is "yes", you will need to sign the form.

15. Consent Form Signature Page

I have reviewed all of the information in this consent form related to the study called:

Experiences of Arab Immigrant Women in Emergency Departments in Halifax Regional Municipality

I have been given the opportunity to discuss this study. All of my questions have been answered to my satisfaction.

This signature on this consent form means that I agree to take part in this study group interview, to have the session audio taped, and to include anonymous quotations from my group interview in publications and presentations from this study. I understand that I am free to withdraw at any time.

_________________ ______________________ _____ / ______ / ____
Signature of Participant Name (Printed) Year Month Day*

___________________ _____________________ _____ / ______ / ____
Signature of Investigator Name (Printed) Year Month Day*

_____ I would like to receive a summary of the final results and a copy of any publication related to this study.

Contact Information

____
____
____
____

***Note: Please fill in the dates personally**

I Will Be Given A Signed Copy Of This Consent Form
Thank you for your time and patience!

Appendix J

Confidentiality Agreement Form

Confidentiality Agreement Form

Study Title: Experiences of Arab Immigrant Women in Emergency Departments in Halifax Regional Municipality

Principal Investigator: Amel AlGallaf, School of Nursing, Dalhousie University
Thesis Supervisor: Dr. Lisa Goldberg, School of Nursing, Dalhousie University

I, _______________ (print name), working as ________________ (transcriptionist/ translator) for the above named study. I agree as part of this work to provide complete confidentiality concerning what has been said in the interviews and the focus group (the group interview) and all the information that I will translate and/or transcribe will remain confidential and will not be shared with any person. I will not talk about any personal identities of any individual who participate in the study. In addition, I will maintain all study data in a secure, locked cabinet or on a secure, password-protected desktop computer.

___________________ _____ /______ /______
Signature of translator or transcriptionist Year Month Day

___________________ _______________________ _____ /______ / _____
Signature of Witness Name of Witness (Printed) Year Month Day

الملحق أ

دليل أسئلة المقابلات

DALHOUSIE UNIVERSITY
Inspiring Minds

دليل أسئلة المقابلات

أرغب في جمع معلومات عن تجارب المرأة العربية المغتربة في أقسام الطوارئ في بلدية هاليفاكس الإقليمية (HRM).

1) نرجو منك وصف تجربتك الأولى في أحد أقسام الطوارئ في HRM؟
(الاستفسارات: متى قصدت قسم الطوارئ؟ من كان يرافقك؟ ما كان شعورك؟)

2) صفي تفاعلاتك مع مزودي الرعاية الصحية والعاملين خلال تجربتك الأولى في قسم الطوارئ؟
(الاستفسارات: الممرضات، الأطباء، المسعفون الطبيون، فريق الدعم)

3) ما هي العوامل الداعمة التي صادفتها خلال زيارتك الأولى لقسم الطوارئ في HRM؟
(الاستفسارات: هل تم الترحيب بك؟ الجو العام؟ الإرشاد؟ هل كنت تعرفين إلى أين يفترض بك التوجه؟ المترجمون؟ مزودو الرعاية الصحية؟ التثقيف؟ المواد: عربي\ إنكليزي؟ الاحتياجات الثقافية؟ جنس مزودي خدمات الرعاية الصحية؟)

4) ما هي التحديات التي واجهتك خلال زيارتك الأولى لأحد أقسام الطوارئ في HRM؟
(الاستفسارات: هل تم الترحيب بك؟ الجو العام؟ الإرشاد؟ مزودو الرعاية الصحية؟ التثقيف؟ اللغة؟ الاحتياجات/الحساسيات الثقافية؟ المترجمون؟)

5) ما هي التعديلات أو التغييرات التي ترغبين في إدخالها على أقسام الطوارئ في HRM؟
(الاستفسارات: ترتيب المرافق \ توفير ورش عمل تثقيفية للمزودين\ مواد التثقيف الصحي باللغة العربية\ المزيد من المترجمين)

6) كيف تعتقدين أنه من الممكن تطبيق هذه التعديلات؟
(الاستفسارات: دعم من صانعي السياسات، استخدام مزودين للرعاية الصحية يتحدثون اللغة العربية و\ أو مترجمين إلى ما هنالك.)

7) كيف تعتقدين أن هذه التعديلات ستساهم في تعزيز \ تمكين تجاربك كامرأة عربية مغتربة في أقسام الطوارئ؟
(الاستفسارات: الوعي الثقافي\ الآثار المترتبة\ التثقيف\ التمييز\ التفكير النمطي القائم على أحكام مسبقة تجاه فئة معينة)

8) هل ترغبين في أن تشاركينا أي شيء آخر اليوم؟

الملحق ب

استبيان لاختيار المرشحات

استبيان لاختيار المرشحات

1) كما تعلمون، أبحث عن مشتركات تتراوح أعمارهنّ ما بين الـ 19 والـ 50 سنة. ما هي الفئة العمرية التي تنتمين إليها؟ 19- 25____، 26-35____ ، 36-50 ____
2) أبحث عن مجموعة متنوعة من السكان يمكن أن تساهم في إثراء دراستي. ما هي جنسيتك؟ _________
3) ما هو بلدك الأم؟ ____________
4) ما هي ديانتك\ نظرتك للعالم؟____________
5) ما هي لغتك الأولى؟____________
6) هل كانت زيارتك لقسم الطوارئ في بلدية هاليفاكس الاقليمية HRM لأول مرة قبل سنتين؟ هل كانت زيارتك كمريضة؟____________
7) ما هو وضعك العائلي؟ ____________
8) هل لديك أولاد؟ كم عددهم؟ ___________

الملحق ج

إعلان التوظيف (بشكل كتابي)

DALHOUSIE
UNIVERSITY
Inspiring Minds

دعوة للمشاركة

كيف كانت تجربتك الاولى كامرأة عربية مغتربة عند زيارتك قسم الطوارئ لأول مرة في هاليفاكس؟

إذا كنت امرأة تتحدث اللغة العربية ويتراوح سنك ما بين 19 و50 سنة، قد تكونين مؤهلة للمشاركة في دراسة بحثية تستعرض قصص نساء عربيات مغتربات استخدمن نظام الرعاية الصحية الكندي عبر أقسام الطوارئ في بلدية هاليفاكس الإقليمية HRM. تشكل هذه الدراسة جزءاً من أطروحة الماجيستر التي أعدها حيث انني طالبة في جامعة دلهاوزي قسم التمريض.

أبحث حالياً عن نساء عربيات مغتربات للمشاركة في مقابلة تتراوح مدتها ما بين 60 و90 دقيقة فضلاً عن مقابلة واحدة للمجموعة. إذا كنت ترغبين في التحدث معي ومشاركتي قصتك، أرجو منك الاتصال بي للحصول على المزيد من المعلومات:

أمل القلاف، على الرقم 902-412-6544 أو عبر البريد الالكتروني am496038@dal.ca
مشرفة البحث:

د. ليزا غولدبيرغ, هاتف 494-2988 (902), البريد الالكتروني Lisa.Goldberg@dal.ca

الملحق د

نص المكالمة الهاتفية

نص المكالمة الهاتفية

مرحباً. أنا أمل القلاف، الباحثة الرئيسية في دراسة تحمل عنوان “ تجارب المرأة العربية المغتربة في أقسام الطوارئ في بلدية هاليفاكس الإقليمية HRM. أود أن أعرّفك أكثر بهذه الدراسة التي تهدف إلى فهم تجارب المرأة العربية المغتربة التي زارت أحد أقسام الطوارئ في HRM خلال السنتين الماضيتين. أعمل في الوقت الحالي على اختيار المشاركات الملائمات للمشاركة في المقابلات و مقابلة للمجموعة. وسأتولى شخصياً إدارة المقابلة التي تتراوح مدتها من 60 إلى 90 دقيقة في المكان والزمان الأنسب إليك. وسيتبع هذه مقابلة للمجموعة تمتد لساعة ونصف تقريباً وتختار مكانها وزمانها المشاركات بالتوافق. يجب أن يتراوح سنك ما بين 19 و50 سنة، وأن تكون اللغة العربية لغتك الأولى. هل لديك أسئلة؟ [في حال وجود اسئلة، سيتم الرد على الأسئلة؛ وفي حال النفي، أضيف ما يلي: هل ترغبين في المشاركة؟ [في حال النفي، أشكرها على وقتها وانهي الاتصال؛ وفي حال الإيجاب، اواصل]

أبحث عن مجموعة متنوعة من السكان يمكن أن تساهم في إثراء هذه الدراسة. نتيجة لذلك، أودّ طرح بعض الأسئلة الشخصية لأتحقق ما إذا كنت تستوفين شروط المشاركة في هذه الدراسة. في حال لم تستوفِ الشروط المطلوبة، سيتم تلف معلوماتك فور انتهاء المكالمة. هل ترغبين في المواصلة؟ [في حال الإيجاب، يمكنك الانتقال إلى الاستبيان الخاص باختيار المرشحات (الملحق ب)؛ وفي حال النفي، أشكرها على وقتها وانهي المكالمة]

الملحق ه

نص البريد الالكتروني

DALHOUSIE UNIVERSITY

Inspiring Minds

نص البريد الالكتروني

مرحباً. تلقيت رسالتك الالكترونية حيث أعربت عن رغبتك في المشاركة في الدراسة " تجارب المرأة العربية المغتربة في أقسام الطوارئ في بلدية هاليفاكس الإقليمية HRM."

أود أن أعرّفك أكثر بهذه الدراسة التي تهدف إلى فهم تجارب المرأة العربية المغتربة التي زارت أحد أقسام الطوارئ في HRM خلال السنتين الماضيتين. أعمل في الوقت الحالي على اختيار المشاركات الملائمات للمشاركة في المقابلات و مقابلة للمجموعة. وسأتولى شخصياً إدارة المقابلة التي تتراوح مدتها من 60 إلى 90 دقيقة في المكان والزمان الأنسب إليك. وسيتبع هذه مقابلة للمجموعة تمتد لساعة ونصف تقريباً وتختار مكانها وزمانها المشاركات بالتوافق. يجب أن يتراوح سنك ما بين 19 و50 سنة، وأن تكون اللغة العربية لغتك الأولى. أبحث عن مجموعة متنوعة من السكان يمكن أن تساهم في إثراء هذه الدراسة. نتيجة لذلك، أودّ طرح بعض الأسئلة الشخصية لأتحقق ما إذا كنت تستوفين شروط المشاركة في هذه الدراسة. في حال لم تستوفِ الشروط المطلوبة، سيتم تلف معلوماتك فور استلام رسالتك الالكترونية.

الأسئلة الشخصية:

1) كما تعلمون، أبحث عن مشتركات تتراوح أعمارهنّ ما بين الـ 19 والـ 50 سنة. ما هي الفئة العمرية التي تنتمين إليها؟ 19- 25____، 26-35____ ، 36-50 ____

2) أبحث عن مجموعة متنوعة من السكان يمكن أن تساهم في إثراء دراستي. ما هي جنسيتك؟ ________

3) ما هو بلدك الأم؟ ____________

4) ما هي ديانتك\ نظرتك للعالم؟____________

5) ما هي لغتك الأولى؟____________

6) هل كانت زيارتك لقسم الطوارئ في بلدية هاليفاكس الاقليمية HRM لأول مرة قبل سنتين؟ هل كانت زيارتك كمريضة؟____________

7) ما هو وضعك العائلي؟ ____________

8) هل لديك أولاد؟ كم عددهم؟ ___________

اذا كان يوجد لديك اسئلة, يمكنك الاتصال بي او ارسال رسالة بالبريد الالكتروني.

اذا كنتي تودين المشاركة, أرجو الاجابة على الأسئلة السابقة و اعادة ارسالها لي.

شكرا جزيلا لوقتك.

أمل القلاف، كلية التمريض، جامعة دلهاوزي
العنوان: 616-3330 بارنستيد لاين، هاليفاكس، نوفا سكوشيا، كندا، B3L0B1 am496038@dal.ca،
هاتف #
(902) 412- 6544

الملحق و

استمارة قبول اجراء المقابلة

استمارة قبول اجراء المقابلة

عنوان الدراسة: تجارب النساء العربيات المغتربات في أقسام الطوارئ في بلدية هاليفاكس الإقليمية

الباحثة الرئيسية:
أمل القلاف، كلية التمريض، جامعة دلهاوزي
العنوان: 3330-616 بارنستيد لاين، هاليفاكس، نوفا سكوشيا، كندا، B3L0B1 am496038@dal.ca،
هاتف # 6544-412 (902)
المشرفة:
الدكتورة ليزا غولدبيرغ، كلية التمريض، جامعة دلهاوزي،
5869 جادة يونيفرسيتي ، ص.ب 15000 هاليفاكس، نوفا سكوشيا B3H4R2، Lisa.Goldberg@dal.ca،
هاتف 2988-494 (902)

1. المقدمة

أنت مدعوة للمشاركة في دراسة بحثية تجريها أمل القلاف، طالبة دراسات عليا في جامعة دلهاوزي، كجزء من أطروحة الماجيستر التي تعدها في إطار برنامج التمريض. إن مشاركتك في هذه الدراسة طوعية ويمكنك الانسحاب منها في أي وقت دون أن يؤثر هذا على جودة الرعاية الصحية الموفرة لك. تجدين في ما يلي وصفاً مفصلاً عن الدراسة نستعرض فيه المخاطر، والفوائد فضلاً عن أي إزعاج قد تشعرين به خلال مشاركتك. من الممكن ألا تستفيدي من مشاركتك في هذه الدراسة، إلا أننا قد نتعلم أشياء قد تعود بالفائدة على الآخرين. يرجى مناقشة جميع الأسئلة التي ترغبين في طرحها حول هذه الدراسة مع أمل القلاف.

2. الغاية من الدراسة

إن الغاية من هذه الدراسة هو جمع المزيد من المعلومات عن تجارب النساء العربيات المغتربات خلال زيارتهنّ الأولى لأقسام الطوارئ في بلدية هاليفاكس الإقليمية HRM. يمكن لتجاربك أن تشمل احتياجاتك، والتحديات التي واجهتها، وتفاعلاتك مع مزودي الرعاية الصحية.

3. تصميم الدراسة

ستشارك ما يتراوح بين ست وثماني نساء عربيات مغتربات في مقابلة تجريها الباحثة الرئيسية.

4. من يستطيع المشاركة في هذه الدراسة

يمكن لأي امرأة عربية مغتربة، يتراوح عمرها ما بين الـ 19 والـ 50 سنة، وتتحدث العربية كلغتها الأولى، تعتنق أي ديانة، وتتمتع بالأهلية العقلية والجسدية للتوقيع على استمارة الموافقة، وكانت قد زارت أي من أقسام الطوارئ في مدينة هاليفاكس لاول مرة خلال السنتين الماضيتين، أن تتأهل للمشاركة في هذه الدراسة. إن المرأة التي تتحدث لغة أولى غير العربية، أو ترعرعت في بلد آخر غير الدول الناطقة باللغة العربية، لا تعتبر مؤهلة للمشاركة في هذه الدراسة.

5. من سيتولى إجراء الدراسة

إن أمل القلاف هي الباحثة الرئيسية والمسؤولة عن إجراء هذا البحث وقيادته. وستكون الدكتورة ليزا غولدبيرغ، الأستاذة في كلية التمريض في جامعة دلهاوزي، المشرفة على هذه الدراسة. ويشارك أيضاً في فريق اللجنة المعنية بالبحث كل من الدكتورة أنريا شيركوب، وهي أستاذة في جامعة دلهاوزي، والدكتورة أماني حمدان، الأستاذة في جامعة الدمام في المملكة العربية السعودية. في حال وافقتِ على المشاركة، ستجرين مقابلة مع الباحثة الرئيسية، أمل القلاف.

6. ما سيُطلب منك فعله

في حال مشاركتك في هذه الدراسة، ستجرين مقابلة واحدة في الوقت والتاريخ الأنسب إليك. وستُطرح عليك أسئلة حول تجاربك خلال زيارتك الأولى لأحد أقسام الطوارئ في بلدية هاليفاكس الإقليمية HRM. ستتراوح مدة المقابلة ما بين 60 إلى 90 دقيقة.

سيتم تسجيل مضمون المقابلة على أشرطة صوتية, عند موافقتك، كما سيتمّ نسخها في وقت لاحق. عند موافقتك على اجراء المشاركة بالدراسة, سيتم استخدام اقتباسات مأخوذة من مقابلتك دون تحديد هويتك عند نشر هذه الدراسة البحثية.

7. المخاطر المحتملة

لا توجد أي مخاطر جسدية مرتبطة بالمشاركة في هذه الدراسة. إلا أنه من الممكن أن تشعري بنوع من الانزعاج عند الإفصاح عن بعض المسائل الشخصية الحساسة. يمكنك الامتناع عن الإجابة عن أي سؤال يشعرك بعدم الارتياح.

8. الفوائد المحتملة

لن تأتي هذه الدراسة بأي فائدة مباشرة عليك، إلا أنها ستساعد على فهم التجارب التي تمر بها المرأة العربية المغتربة عند زيارتها أحد أقسام الطوارئ في HRM. فمن خلال لفت انتباه مزودي الرعاية الصحية إلى تجارب المرأة العربية المغتربة وحاجاتها، سنساعدهم على توفير رعاية آمنة وعادلة، تراعي المعايير الأخلاقية والثقافية وتتمتع بمستوى عالٍ من الكفاءة. ومن الممكن أن تقدم النتائج التي ستخلص إليها هذه الدراسة بيانات تكون اساسا لدراسات اخرى مستقبلية, جميعها قد تحمل صانعي القرارات والمنظمات الأخرى على إعادة النظر في سياساتهم الحالية وتغييرها بما يتيح مراعاة الحساسيات والاعتبارات الثقافية في مجال الرعاية الصحية, كما يمكن أن تساهم في وضع الخطط التوجيهية لممارسات افضل، وتحسين المناهج التعليمية فضلاً عن تشجيع

التعليم المتواصل لمزودي الرعاية الصحية المعنيين برعاية النساء العربيات المغتربات، لاسيما على صعيد النساء العربيات المغتربات المقيمات في نوفا سكوشيا، ما يمكن أن يساهم في تحسين نوعية الحياة للنساء العربيات المغتربات.

9. البدل \ التعويض المادي

لن يُدفع أي بدل عيني.

10. السرية والخصوصية

<u>الخصوصية</u>

جميع المعلومات التي ستجمع ستعطى لشخص يدون مضمون التسجيل. سيُطلب من الشخص المسؤول عن تدوين مضمون التسجيلات الصوتية إخفاء هويتك، وستُستعمل الأسماء المستعارة في كل مرة نقتبس فيها بعضاً من حديثك أو تجربتك لإدراجه في الدراسة. وسيحرص الباحث الرئيسي على حفظ اسمك ومعلومات الاتصال الخاصة بك في صندوق مقفل امن في مكتب في منزل الباحث الرئيسي وعدم مشاركتها مع الآخرين. بالإضافة إلى هذا، لن يظهر اسمك في أي من التقارير أو المقالات التي ستُنشر إثر هذه الدراسة.

<u>السرية</u>

سيقوم الباحث الرئيسي بجمع واستعمال المعلومات اللازمة لإنجاز الدراسة فحسب. لن تُستخدم هذه المعلومات إلا لأهداف هذه الدراسة، وهي تشمل ما يلي:

- سنك
- جنسيتك
- لغتك الأولى
- بلدك الأم
- ديانتك
- وضعك العائلي
- الأولاد
- المعلومات التي تم جمعها خلال المقابلات التي أجريت في إطار الدراسة

ستُحتفظ الأشرطة الصوتية حين لا تكون مستخدمة في خزانة مقفلة وستُتلف بعد الانتهاء من تدوينها. استمارات قبول المشاركة في الدراسة ستحفظ ايضا في خزانة اخرى مقفلة. كما سيوضع جهاز الكومبيوتر المستخدم خلال هذه الدراسة بالاضافة الى الاستمارات بعد نسخها في خزانة مقفلة وسيزود بكلمة مرور. الأشرطة الصوتية, استمارات قبول المشاركة بالدراسة, البيانات المجمعة, الكمبيوتر المستخدم, و البيانات المنسوخة ستحفظ في مكتب العمل في منزلي و سيكون الباب مقفل عند عدم استخدام البيانات. الباحثة الرئيسية, أمل القلاف، ستكون المسؤولة عن أمن المعلومات وحمايتها.

في ما يتعلق بالأشرطة الصوتية المسجلة باللغة العربية، سيتولى مترجم ترجمتها إلى اللغة الانكليزية.

كما ستُسلم الأشرطة الصوتية كلها إلى ناسخ التسجيلات الصوتية. وسيُطلب من المترجم وناسخ التسجيلات الصوتية التوقيع على استمارة السرية حرصاً على ضمان سرية المعلومات والحد من احتمال خرقها.

11. الأسئلة

للحصول على المزيد من المعلومات عن الدراسة، يرجى الاتصال بأمل القلاف، الباحثة الرئيسية، على رقم الهاتف التالي 6544-412 (902). يمكنك ايضا الاتصال بالدكتورة ليزا غولدبيرغ, على رقم الهاتف التالي (902) 494-2988

12. معلومات جديدة

من الممكن (رغم أن الأمر بعيد الاحتمال) أن تتوفر معلومات جديدة خلال مشاركتك في الدراسة قد تؤثر على صحتك، أو رفاهيتك أو رغبتك في إتمام هذه الدراسة. في حال حدوث ذلك، سيتم إبلاغك في حينه وسنسألك ما إذا كنت تريدين الاستمرار في المشاركة أم لا.

13. **حقوقك**

يمكنك في أي وقت أن تطالبي بوقف المقابلة، أخذ استراحة أو الامتناع عن الإجابة عن أي من الأسئلة. وإذا غيرت رأيك وقت اجراءالمقابلة و قررتي عدم اكمالها، يمكنك الانسحاب في أي وقت. في حال كنت ترغبين بالانسحاب، نرجو منك إبلاغ الباحثة الرئيسية. تُحتفظ البيانات التي تم جمعها لغاية تاريخ سحب موافقتك في سجلات الدراسة، ويتم إدراجها في التحاليل المتصلة بالدراسة إلا في حال أشرت صراحة إلى عدم رغبتك بإدراج هذه البيانات. بعد توقيعك على استمارة الموافقة على اجراء المقابلة، سيتم تزويدك بنسخة عنها. وفي نهاية الدراسة، ستتم مناقشة النتائج مع المشاركات الراغبات في ذلك. كما سيتم تزويدهن بنسخة عن أي مقالة ذات صلة يتم نشرها إذا ما رغبن في ذلك.

14. **المخاوف أو المشاكل؟**

إذا كنت تواجهين صعوبة أو ترغبين في التعبير عن مخاوفك حيال أي جانب من جوانب مشاركتك في هذه الدراسة، يمكنك الاتصال بالسيدة كاثرين كونورز، رئيس مكتب إدارة أخلاقيات البحوث البشرية في جامعة دلهاوزي، على الرقم التالي 1462-494 (902) للحصول على المساعدة والتوجيه.

سنسألك في القسم التالي ما إذا كنت تقبلين (توافقين على) المشاركة في هذه الدراسة. وفي حال الإيجاب، سيُطلب منك التوقيع على استمارة الموافقة.

15. صفحة التوقيع على استمارة الموافقة

لقد راجعت كافة المعلومات الواردة في استمارة الموافقة والمتعلقة بهذه الدراسة التي تحمل العنوان التالي:

تجارب المرأة العربية المغتربة في أقسام الطوارئ في بلدية هاليفاكس الإقليمية

لقد أتيحت أمامي فرصة مناقشة هذه الدراسة. وقد تمت الإجابة على كافة الأسئلة التي طرحتها بما يرضيني.

إن توقيعي على استمارة الموافقة هذه يفيد أنني على استعداد للمشاركة في هذه الدراسة، و الموافقة على إدراج اقتباسات مأخوذة من مقابلتي دون تحديد هويتي وذلك في النشرات والعروض التقديمية الخاصة بهذه الدراسة. وأنني أدرك أنني أملك حرية الانسحاب منها في أي وقت أشاء.

________________ ________________ _____ / _______ / ______

توقيع المشاركة الاسم (مطبوع) السنة الشهر اليوم*

________________ ________________ _____ / _______ / ______

توقيع الباحث الاسم (مطبوع) السنة الشهر اليوم*

أوافق على تسجيل المقابلة.

________________ ________________ _____ / _______ / ______

توقيع المشاركة الاسم (مطبوع) السنة الشهر اليوم*

______**أودّ الحصول على موجز عن النتائج النهائية ونسخة عن كافة المنشورات المتعلقة بهذه الدراسة.**

معلومات الاتصال

***ملاحظة: الرجاء ملء التواريخ شخصياً.**

سأحصل على نسخة موقعة من استمارة الموافقة هذه

شكراً على وقتكم وتعاونكم!

الملحق ز

استمارة قبول اجراء مقابلة المجموعة

DALHOUSIE
UNIVERSITY
Inspiring Minds

استمارة قبول اجراء مقابلة المجموعة

عنوان الدراسة: تجارب النساء العربيات المغتربات في أقسام الطوارئ في بلدية هاليفاكس الإقليمية

الباحثة الرئيسية:

أمل القلاف، كلية التمريض، جامعة دلهاوزي
العنوان: 616-3330 بارنستيد لاين، هاليفاكس، نوفا سكوشيا، كندا، B3L0B1 am496038@dal.ca،
هاتف # 6544-412 (902)

المشرفة:

الدكتورة ليزا غولدبيرغ، كلية التمريض، جامعة دلهاوزي،
5869 جادة يونيفرسيتي ، ص.ب 15000 هاليفاكس، نوفا سكوشيا B3H4R2، Lisa.Goldberg@dal.ca،
هاتف 2988-494 (902)

1. المقدمة

أنت مدعوة للمشاركة في دراسة بحثية تجريها أمل القلاف، طالبة دراسات عليا في جامعة دلهاوزي، كجزء من أطروحة الماجيستر التي تعدها في إطار برنامج التمريض. إن مشاركتك في هذه الدراسة طوعية ويمكنك الانسحاب منها في أي وقت دون أن يؤثر هذا على جودة الرعاية الصحية الموفرة لك. تجدين في ما يلي وصفاً مفصلاً عن الدراسة نستعرض فيه المخاطر، والفوائد فضلاً عن أي إزعاج قد تشعرين به خلال مشاركتك. من الممكن ألا تستفيدي من مشاركتك في هذه الدراسة، إلا أننا قد نتعلم أشياء قد تعود بالفائدة على الآخرين. يرجى مناقشة جميع الأسئلة التي ترغبين في طرحها حول هذه الدراسة مع أمل القلاف.

2. الغاية من الدراسة

إن الغاية من هذه الدراسة هو جمع المزيد من المعلومات عن تجارب النساء العربيات المغتربات خلال زيارتهنّ الأولى لأقسام الطوارئ في بلدية هاليفاكس الإقليمية HRM. يمكن لتجاربك أن تشمل احتياجاتك، والتحديات التي واجهتها، وتفاعلاتك مع مزودي الرعاية الصحية.

3. تصميم الدراسة

ستشارك في مقابلة واحدة للمجموعة بوجود الباحثة الرئيسية.

4. من يستطيع المشاركة في هذه الدراسة

يمكن لأي امرأة عربية مغتربة، يتراوح عمرها ما بين الـ 19 والـ 50 سنة، وتتحدث العربية كلغتها الأولى، تعتنق أي ديانة، وتتمتع بالأهلية العقلية والجسدية للتوقيع على استمارة الموافقة، وكانت قد زارت أي من أقسام الطوارئ في مدينة هاليفاكس لاول مرة خلال السنتين الماضيتين، أن تتأهل للمشاركة في هذه الدراسة. إن المرأة التي تتحدث لغة أولى غير العربية، أو ترعرعت في بلد آخر غير الدول الناطقة باللغة العربية، لا تعتبر مؤهلة للمشاركة في هذه الدراسة.

5. من سيتولى إجراء الدراسة

إن أمل القلاف هي الباحثة الرئيسية والمسؤولة عن إجراء هذا البحث وقيادته. وستكون الدكتورة ليزا غولدبيرغ، الأستاذة في كلية التمريض في جامعة دلهاوزي، المشرفة على هذه الدراسة. ويشارك أيضاً في فريق اللجنة المعنية بالبحث كل من الدكتورة أنريا شيركوب، وهي أستاذة في جامعة دلهاوزي، والدكتورة أماني حمدان، الأستاذة في جامعة الدمام في المملكة العربية السعودية. في حال وافقتِ على المشاركة، ستشاركين في مقابلة جماعية بوجود الباحثة الرئيسية، أمل القلاف.

6. ما سيُطلب منك فعله

في حال مشاركتك في هذه الدراسة، سيطلب منك أن تشاركي في مقابلة للمجموعة تستمر من 60 إلى 90 دقيقة، حيث ستناقشين تجربتك خلال زيارتك الأولى لأحد أقسام الطوارئ في HRM. وتجدر الإشارة إلى أن كافة المعلومات التي سيتمّ المشاركة بها في إطار مقابلة المجموعة ستبقى سرية. لكن الاشخاص المشاركين من الممكن انهم يشاركون معلومات تم طرحها في المقابلة الجماعية مع اخرين. لذلك السرية في مقابلة المجموعة غير مضمونة.

سيتم تسجيل مضمون مقابلة المجموعة على شريط صوتي، كما سيتمّ نسخه في وقت لاحق. كما سيتم إدراج اقتباسات مأخوذة من مقابلتك دون تحديد هويتك عند نشر هذه الدراسة البحثية.

7. المخاطر المحتملة

لا توجد أي مخاطر جسدية مرتبطة بالمشاركة في هذه الدراسة. إلا أنه من الممكن أن تشعري بنوع من الانزعاج عند الإفصاح عن بعض المسائل الشخصية الحساسة. يمكنك الامتناع عن الإجابة عن أي سؤال يشعرك بعدم الارتياح.

8. الفوائد المحتملة

لن تأتي هذه الدراسة بأي فائدة مباشرة عليك، إلا أنها ستساعد على فهم التجارب التي تمر بها المرأة العربية المغتربة عند زيارتها أحد أقسام الطوارئ في HRM. فمن خلال لفت انتباه مزودي الرعاية الصحية إلى تجارب المرأة العربية المغتربة وحاجاتها، سنساعدهم على توفير رعاية آمنة وعادلة، تراعي المعايير الأخلاقية والثقافية وتتمتع بمستوى عالٍ من الكفاءة. ومن الممكن أن تقدم النتائج التي ستخلص إليها هذه الدراسة بيانات تكون اساسا لدراسات اخرى مستقبلية, جميعها قد تحمل صانعي القرارات والمنظمات الأخرى على إعادة النظر في سياساتهم الحالية وتغييرها بما يتيح مراعاة الحساسيات والاعتبارات الثقافية في مجال الرعاية الصحية, كما يمكن أن

تساهم في وضع الخطط التوجيهية لممارسات افضل، وتحسين المناهج التعليمية فضلاً عن تشجيع التعليم المتواصل لمزودي الرعاية الصحية المعنيين برعاية النساء العربيات المغتربات، لاسيما على صعيد النساء العربيات المغتربات المقيمات في نوفا سكوشيا، ما يمكن أن يساهم في تحسين نوعية الحياة للنساء العربيات المغتربات.

9. البدل \ التعويض المادي

لن يُدفع أي بدل عيني.

10. السرية والخصوصية

الخصوصية

جميع المعلومات التي ستجمع ستعطى لشخص يدون مضمون التسجيل. سيُطلب من الشخص المسؤول عن تدوين مضمون التسجيلات الصوتية إخفاء هويتك، وستُستعمل الأسماء المستعارة في كل مرة نقتبس فيها بعضاً من حديثك أو تجربتك لإدراجه في الدراسة. وسيحرص الباحث الرئيسي على حفظ اسمك ومعلومات الاتصال الخاصة بك في صندوق مقفل امن في مكتب العمل في منزل الباحث الرئيسي وعدم مشاركتها مع الآخرين. بالإضافة إلى هذا، لن يظهر اسمك في أي من التقارير أو المقالات التي ستُنشر إثر هذه الدراسة.

السرية

سيقوم الباحث الرئيسي بجمع واستعمال المعلومات اللازمة لإنجاز الدراسة فحسب. لن تُستخدم هذه المعلومات إلا لأهداف هذه الدراسة، وهي تشمل ما يلي:

- سنك
- جنسيتك
- لغتك الأولى
- بلدك الأم
- ديانتك
- وضعك العائلي
- الأولاد
- المعلومات التي تم جمعها خلال مقابلة المجموعة التي أجريت في إطار الدراسة

سيحفظ الشريط الصوتي حين لا يكون مستخدما في خزانة مقفلة وسيُتلف بعد الانتهاء من تدوينه.

استمارات قبول المشاركة في الدراسة ستحفظ ايضا في خزانة اخرى مقفلة. كما سيوضع جهاز الكومبيوتر المستخدم خلال هذه الدراسة بالاضافة الى الاستمارات بعد نسخها في خزانة مقفلة وسيزود بكلمة مرور. الشريط الصوتي, استمارات قبول المشاركة بالدراسة, البيانات المجمعة, الكمبيوتر المستخدم, و البيانات المنسوخة ستحفظ في مكتب العمل في منزلي و سيكون الباب مقفل عند عدم استخدام البيانات. الباحثة الرئيسية, أمل القلاف، ستكون المسؤولة عن أمن المعلومات وحمايتها.

في ما يتعلق بالشريط الصوتي، سيتولى مترجم ترجمته إلى اللغة الانكليزية. ثم يسلم إلى ناسخ

التسجيلات الصوتية. وسيُطلب من المترجم وناسخ التسجيلات الصوتية التوقيع على استمارة السرية حرصاً على ضمان سرية المعلومات والحد من احتمال خرقها.

11. الأسئلة

للحصول على المزيد من المعلومات عن الدراسة، يرجى الاتصال بأمل القلاف، الباحثة الرئيسية، على رقم الهاتف التالي 6544-412 (902). يمكنك ايضا الاتصال بالدكتورة ليزا غولدبيرغ, على رقم الهاتف التالي (902) 494-2988

12. معلومات جديدة

من الممكن (رغم أن الأمر بعيد الاحتمال) أن تتوفر معلومات جديدة خلال مشاركتك في الدراسة قد تؤثر على صحتك، أو رفاهيتك أو رغبتك في إتمام هذه الدراسة. في حال حدوث ذلك، سيتم إبلاغك في حينه وسنسألك ما إذا كنت تريدين الاستمرار في المشاركة أم لا.

13. حقوقك

يمكنك أخذ استراحة أو الامتناع عن الإجابة عن أي من الأسئلة. وإذا غيرت رأيك وقت اجراء المقابلة و قررتي عدم اكمالها، يمكنك الانسحاب في أي وقت. في حال كنت ترغبين بالانسحاب، نرجو منك إبلاغ الباحثة الرئيسية. تُحتفظ البيانات التي تم جمعها لغاية تاريخ سحب موافقتك في سجلات الدراسة، ويتم إدراجها في التحاليل المتصلة بالدراسة إلا في حال أشرت صراحة إلى عدم رغبتك بإدراج هذه البيانات. بعد توقيعك على استمارة الموافقة على اجراء المقابلة، سيتم تزويدك بنسخة عنها. وفي نهاية الدراسة، ستتم مناقشة النتائج مع المشاركات الراغبات في ذلك. كما سيتم تزويدهن بنسخة عن أي مقالة ذات صلة يتم نشرها إذا ما رغبن في ذلك.

14. المخاوف أو المشاكل؟

إذا كنت تواجهين صعوبة أو ترغبين في التعبير عن مخاوفك حيال أي جانب من جوانب مشاركتك في هذه الدراسة، يمكنك الاتصال بالسيدة كاثرين كونورز، رئيس مكتب إدارة أخلاقيات البحوث البشرية في جامعة دلهاوزي، على الرقم التالي 1462-494 (902) للحصول على المساعدة والتوجيه.

سنسألك في القسم التالي ما إذا كنت تقبلين (توافقين على) المشاركة في هذه الدراسة. وفي حال الإيجاب، سيُطلب منك التوقيع على استمارة الموافقة.

15. صفحة التوقيع على استمارة الموافقة

لقد راجعت كافة المعلومات الواردة في استمارة الموافقة والمتعلقة بهذه الدراسة التي تحمل العنوان التالي:

تجارب المرأة العربية المغتربة في أقسام الطوارئ في بلدية هاليفاكس الإقليمية

لقد أتيحت أمامي فرصة مناقشة هذه الدراسة. وقد تمت الإجابة على كافة الأسئلة التي طرحتها بما يرضيني.
إن توقيعي على استمارة الموافقة هذه يفيد أنني على استعداد للمشاركة في هذه الدراسة, و الموافقة على التسجيل الصوتي، و الموافقة على إدراج اقتباسات مأخوذة من مقابلة المجموعة دون تحديد هويتي وذلك في النشرات والعروض التقديمية الخاصة بهذه الدراسة .وأنني أدرك أنني أملك حرية الانسحاب منها في أي وقت أشاء.

____________________	__________________	_____ / _______ / ______
توقيع المشاركة	الاسم (مطبوع)	السنة الشهر اليوم*
____________________	__________________	_____ / _______ / ______
توقيع الباحث	الاسم (مطبوع)	السنة الشهر اليوم*

______أودّ الحصول على موجز عن النتائج النهائية ونسخة عن كافة المنشورات المتعلقة بهذه الدراسة.

معلومات الاتصال

____

____

____

____

____

***ملاحظة: الرجاء ملء التواريخ شخصياً.**

سأحصل على نسخة موقعة من استمارة الموافقة هذه

شكراً على وقتكم وتعاونكم

الملحق ح

استمارة اتفاقية السرية

DALHOUSIE
UNIVERSITY
Inspiring Minds

استمارة اتفاقية السرية

عنوان الدراسة: تجارب المرأة العربية المغتربة في أقسام الطوارئ في مدينة هاليفاكس

الباحثة الرئيسية: أمل القلاف، كلية التمريض، جامعة دلهاوزي.

مشرفة البحث: الدكتورة ليزا غولدبيرغ, كلية التمريض, جامعة دلهاوزي.

أنا_______________ (الاسم مطبوع)، _______________ (ناسخ مضمون التسجيلات الصوتية \ مترجم) الدراسة المشار إليها أعلاه، أوافق، في إطار العمل الذي أقوم به، على الحفاظ على سرية المعلومات الواردة في المقابلات ومجموعة النقاش، وأتعهد بالحفاظ على سرية كافة المعلومات التي يُفترض بي ترجمتها و\او نسخها وعدم مشاركتها مع أي شخص آخر. وأتعهد أيضاً بألا أتحدث عن أي هويات شخصية عائدة للأشخاص الذين شاركوا في الدراسة، كما أحرص على إبقاء كافة البيانات الخاصة بالدراسة في خزانة مقفلة وآمنة أو على جهاز كومبيوتر مزود بكلمة مرور للحماية.

______________________ ____ / ______ / _____

توقيع مترجم أو ناسخ محتويات التسجيلات الصوتية السنة الشهر اليوم

______________________ __________________ ____ ______ / _____

توقيع الشاهد اسم الشاهد (مطبوع) السنة الشهر اليوم