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Exploring the Need Experience of Nurses in a Multicultural Healthcare Setting

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ABSTRACT

This qualitative descriptive study explored the unique bedside 'need experience,' linguistic and non-verbal communication barriers, and daily operational pressures encountered by frontline Filipino expatriate clinicians in the United Arab Emirates (UAE). Grounded in qualitative descriptive methodology, semi-structured interviews were conducted with a purposive sample of fifteen (15) Filipino expatriate nurses working within a private, secondary-care healthcare facility in Dubai. Data analysis followed a rigorous thematic analysis model to identify recurring patterns of culture-based barriers, systematic unit impacts, and adaptive coping mechanisms. The study uncovered critical linguistic-cultural boundaries, including clinical vocabulary deficits during acute symptom assessments and complex patriarchal family dynamics. These communication gaps directly compromised patient safety by creating false affirmation loops ("Inshallah, yes") during critical discharge instructions while generating extensive operational workflow and medical handoff delays across shifts. To manage these routine pressures and mitigate moral distress, the clinicians relied heavily on self-generated makeshift digital tools, visual cues, and informal peer support networks. Ultimately, the findings emphasized the critical need for healthcare institutions to move beyond standard operational orientations and actively implement structured, culturally tailored communication training frameworks to safeguard patient safety and support expatriate nurses' well-being.

Keywords: *Multicultural Healthcare, Expatriate Nurses, Cultural Communication, Need Experience, Qualitative Descriptive, UAE*

INTRODUCTION

Bedside communication breakdowns directly threaten clinical safety, diagnostic accuracy, and patient outcomes (Gerchow et al., 2021). While the Philippine Nursing Act of 2002 (R.A No. 9173) mandates cultural competence, navigating cross-cultural realities requires rapid clinical adaptation (Atta et al., 2025). This challenge is acute in the UAE, where 98.5% of the nursing workforce consists of expatriates facing language barriers and family-centered dynamics (Al-Yateem et al., 2023). Although literature emphasizes cultural education, an empirical gap remains regarding qualitative evaluations of the "need experience" from frontline clinicians' perspectives (Paredath et al., 2023).

This study addressed this gap by exploring expatriate nurses' "need experience" and communication challenges in multicultural UAE settings. Capturing these firsthand accounts helps identify professional support requirements to maintain patient safety, optimize operational efficiency, and refine training protocols (Rawas et al., 2025). Ultimately, these

insights provide administrators with the baseline data needed to refine regional safety frameworks and workforce policies.

Statement of the Problem

This study analyzed how expatriate nurses describe their 'need experience' and cultural communication barriers within multicultural UAE healthcare settings. Specifically, it examined the explicit cultural, non-verbal, and religious communication boundaries encountered during bedside care; how these complexities influence patient safety and operational workflow efficiency; and the adaptive coping strategies and support systems utilization by nursing professionals to manage day-to-day operational pressures.

Scope and Delimitations

This study examined the subjective 'need experience' and cultural communication barriers of 15 Filipino expatriate nurses currently working in private, secondary-care healthcare facilities in Dubai during the first half of 2026. Inclusion criteria required Filipino nationality, ages 25–45, and a minimum of three years of clinical nursing experience within the UAE. Findings apply specifically to multicultural private hospital setups in the region and cannot be generalized to broader public healthcare systems.

Review of Related Literatures

The global healthcare landscape is defined by massive cultural and linguistic complexity that directly dictates the quality of patient care. In the UAE's diverse clinical settings, profound "hidden" barriers root themselves in non-verbal behaviors and religious subtleties that standard training programs frequently overlook (Al-Yateem et al., 2023). Beyond simple confusion, bedside language gaps and differing health beliefs serve as primary drivers behind serious medical errors, poor safety protocol compliance, and discharge education delays (Rawas et al., 2025). For expatriate nurses, migrating requires navigating intense psychological strain, raw language barriers, fractured social connections, and a distinct loss of professional autonomy (Koseoglu Ornek et al., 2022).

To survive within these multicultural spaces, clinicians must continuously build cultural awareness to bridge the gap between specific clinical needs and daily operations. When healthcare facilities fail to offer culturally tailored communication protocols, frontline staff are left to rely on ad-hoc, makeshift interactions, which significantly increases the risk of clinical mistakes (Alharazi et al., 2025). This lack of structural support forces expatriate nurses to constantly balance humanism and technology without a break, resulting in acute moral distress and burnout (Paredath et al., 2023). Because nurse well-being is intrinsically linked to patient safety, clinical leaders must move past generic administrative onboarding and implement practical, evidence-based integration strategies (Bonito & Merced, 2026). Providing structured onboarding plans ultimately improves operational readiness, answers the unique 'need experience' of expatriate staff, reduces turnover, and secures hospital-wide safety.

Theoretical Framework

The synthesis of Patricia Benner's ***Novice to Expert Model***, Madeleine Leininger's ***Culture Care Diversity and Universality Theory***, and Virginia Henderson's ***Nursing Need***

Theory served as the structural foundation of this study. Benner's model was used to observe the professional "reset" of highly competent Filipino nurses who were momentarily returned to the advanced beginner stage due to an unfamiliar institutional and cultural environment. Leininger's was used to demonstrate the need for cultural congruence, in which technical clinical skills must be structurally congruent with the beliefs and lifestyles of the diverse patient population to be effective. Finally, the study provided a unique pivot of Henderson's Nursing Need Theory, focusing specifically on the 10th component (communicating emotions, needs, or opinions) and the 11th component (worshiping according to one's faith). Henderson's model served as the primary conceptual lens to analyze how systematic communication barriers and religious transitions interfered with, altered, or threatened the nurse's own 'need experience' and their subsequent ability to deliver safe, holistic, and independent bedside care.

METHODOLOGY

This section outlines the research design, participant selection, data collection procedures, ethical considerations, and thematic analysis methods used to conduct the study.

Research Design

This qualitative research was conducted to explore the subjective 'need experience' and cultural communication barriers of Filipino expatriate nurses working in a private healthcare setting in the UAE. The study employed a Qualitative Descriptive (QD) research design that provided a simple, comprehensive summary of the participants' experiences in everyday language. This design allowed the researcher to gather detailed, real-time narratives of clinical safety risks and operational inefficiencies directly from the source, without the constraints of highly abstract philosophical theories or statistical testing.

Research Steps

The research started with an extensive literature review to create a solid basis on issues like linguistic-cultural barriers, safety risks associated with patients, and international nursing transitions within a multicultural healthcare setting. The qualitative methods of data gathering obtained detailed personal narratives from the participants through valid semi-structured interviews. After gathering all required data, the obtained transcripts underwent thematic analysis to identify the main themes in the area of bedside communication barriers, influence on the unit operations, and coping strategies. The process concluded with the synthesis of these findings to propose a comprehensive framework for improving cultural competence and clinical safety.

Data Collection and Sample Selection

Participants were selected using a non-probability purposive sampling method to recruit a heterogeneous group of 15 Filipino expatriate nurses working at a Joint Commission International (JCI) accredited private, secondary-care hospital in Dubai. Each semi-structured interview lasted approximately 40 to 60 minutes and was conducted face-to-face or online based on participant preference. All interviews were audio-recorded with the participants' explicit written permission.

Data Analysis Methods

Data were analyzed qualitatively, in a thematic manner, whereby verbal narratives from the semi-structured transcripts were systematically classified in accordance with Braun and Clarke's 6-Step Model. This involved becoming familiar with the data through rereading, generating initial codes for communication difficulties, and clustering them into candidate thematic groupings. Candidate groupings were cross-checked against the whole dataset to ensure that they accurately represented participants' experiences and to establish thematic redundancy. The final themes were then defined and named, and woven into a structured narrative report. This rigorous analysis formed the empirical basis for developing targeted educational interventions.

Research Hypotheses and Validation

As a qualitative descriptive study, no formal statistical hypotheses were proposed. Trustworthiness was established through credibility, dependability, and confirmability. To ensure tool validity, three experts in nursing education, practice, and qualitative methods evaluated the semi-structured interview guide prior to data collection. Additionally, pilot testing with two Filipino expatriate nurses refined the questions and verified the clarity of the grand tour question.

Study Limitations and Ethical Considerations

This research strictly adhered to ethical considerations through the acquisition of institutional permission and the process of seeking consent from all participants, and ensured that there was absolute confidentiality and the right of withdrawal from the research at any stage. No personal identifiers were revealed, and pseudonyms (like Nurse A, Nurse B) were used when referring to the participants in all papers. Ethical considerations were taken care of by adhering to ethical principles such as autonomy, beneficence, non-maleficence, justice, confidentiality, anonymity, fidelity, and veracity. The methodology used in the research involved interviewing only Filipino nationals aged 25 to 45 who had at least 3 years of experience in the UAE.

RESULTS AND DISCUSSION

The qualitative data gathered from the participants provided a comprehensive narrative of the 'need experience' of Filipino expatriate nurses navigating the "third space" of UAE healthcare. The thematic analysis of the transcripts produced three distinct cluster themes that directly address the grand tour question regarding their unique bedside need experiences and communication challenges.

Cluster 1: Linguistic Disconnection & Familial Interventions: Participants detailed an immediate professional challenge stemming from acute vocabulary deficits when assessing elderly or local Arabic-speaking patients. While basic transactional phrases were easily memorized, they proved insufficient for decoding complex clinical symptoms or pain thresholds. Furthermore, clinicians frequently encountered intense non-verbal boundaries driven by traditional patriarchal family dynamics. The constant presence of large family networks required nurses to be hyper-vigilant regarding cultural modesty customs, heavily impacting the pacing and delivery of routine bedside interventions.

Cluster 2: Systemic Near-Misses & Instructional Vulnerabilities: The narratives revealed that language discordance directly introduced systemic vulnerabilities within the unit's operational workflow. A major hazard identified was the phenomenon of false comprehension, where patients politely nodded and affirmed instructions (*"Inshallah, yes"*) despite completely misunderstanding critical clinical education. This communication breakdown created severe post-discharge risks and medication near-misses that required constant double-checking. Additionally, the lack of real-time translation support systematically delayed patient handoffs and care execution across shifts.

Cluster 3: Peer-Reliance & Deficits in Institutional Frameworks: To mitigate these daily operational pressures, frontline clinicians relied almost exclusively on self-generated, ad-hoc strategies. Nurses enforced strict physical return-demonstrations for high-alert discharge tasks, utilized uncertified smartphone translation applications, and deployed color-coded visual aids. To manage the resulting moral distress and prevent professional burnout, the clinicians depended heavily on informal peer decompression and venting within staff breakrooms, exposing a critical deficit in structured institutional onboarding and cultural competence training.

SUMMARY

The qualitative research carried out among the expatriate nursing staff unveiled a profound connection between linguistic-cultural boundaries, operational workflow degradation, and frontline coping mechanisms. Nurses demonstrated clear resilience by deploying makeshift translation tools, rigid visual cues, and strict return-demonstration protocols to intercept clinical near-misses caused by false patient affirmation loops. However, the reliance on informal peer decompression to manage severe operational stress highlights that technical clinical expertise is systematically undermined without formal institutional support. These findings confirm that achieving comprehensive cultural congruence is an essential prerequisite for safeguarding patient safety and maintaining workforce stability in globalized healthcare settings.

CONCLUSION

This study demonstrated that Filipino expatriate nurses experience a temporary professional "reset" within the multicultural healthcare ecosystem of the UAE, transitioning from expert practitioners back to the advanced beginner stage due to unfamiliar linguistic, familial, and religious boundaries at the bedside. This pervasive language discordance, combined with complex cultural expectations, directly compromises patient safety by introducing deceptive affirmation loops during patient education while simultaneously undermining operational efficiency through systematic clinical handoff and shift delays. Because the adaptive strategies utilized by frontline clinicians remain entirely self-generated and peer-dependent, these findings expose a critical gap in institutional frameworks. Ultimately, this underscores an urgent need for private healthcare facilities to transition away from generic orientations and implement structured, evidence-based cultural communication training programs to safeguard patient care.

RECOMMENDATIONS

Healthcare administrators in the private sector should design and implement structured cultural communication modules during institutional onboarding. These programs must move away from generic guidelines and focus directly on providing practical conversational Arabic training, detailed modesty protocols for diverse clinical settings, and visual aids for bedside staff. Additionally, continuous evaluation of nursing workloads and clinical outcomes will guarantee that communication training frameworks continue to have a beneficial effect on patient safety, shift handoff efficiency, and nurse retention.

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AI DECLARATION STATEMENT

The author used artificial intelligence (AI) tools solely to assist with grammatical editing, structural formatting, and proofreading to ensure compliance with the target journal's length constraints. No AI tools were used to generate original data, conduct qualitative thematic analysis, or fabricate text. The authors take full responsibility for the content and integrity of the final manuscript.

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