Intersectional employee voice inequalities and culture care theory: the case of migrant palliative care nurses in Saudi Arabia

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Abstract

Purpose – This narrative literature review examines intersectional employee voice inequalities in a non-western high power-distance context to develop a multi-level conceptual framework.

Design/methodology/approach – The authors use Leininger's (1997, 2002) culture care model to explore the influence of multi-level dimensions on intersectional voice inequalities based on the 31 studies reviewed applied to specific challenges for migrant palliative care nurses in Saudi Arabia.

Findings – The themes identified how better transcultural communications might mitigate voice inequalities that influence migrant employee well-being and intentions to quit resulting from cultural incongruities.

Originality/value – The impact of national culture differences and intersectional inequalities on employee voice has largely been ignored in academic research. This paper offers unique insights into intersectional voice challenges from a non-western perspective in the under-researched setting of Saudi Arabia which is mid-way through a national transformation programme. It starkly contrasts policy ambitions for advancing health care and discriminatory practices based on conservative attitudes which stifle migrant worker voices.

Keywords Culture care theory, Employee voice, Intersectional inequalities, National culture, Palliative care, Saudi Arabia

Introduction

Employee voice refers to employee views and participation which impact on organisational decision-making (Elsetouhi *et al*., 2022). Experiences may vary across different cultures (Wilkinson *et al*., 2023) yet we know little about voice challenges in non-western contexts where foreign employees may experience multiple sources of disadvantage. Rodriguez (2024: 41) notes "[t]he premise of intersectional thinking is that distinct socially constructed categories of difference (e.g., gender, race, age, disability, among others) do not operate independently to create inequality but that the simultaneity and complexity of these categories comes together to produce power relations that result in privilege and disadvantage."

To understand intersectional perspectives on foreign employee voice, this review paper considers how healthcare workers, specifically migrant nurses, with different nationalities work in high power-distance contexts that present particular cross-cultural challenges (Kwon and Farndale, 2020). Clearly, in healthcare organisations, managers ignoring employees' voices can have adverse consequences for patients (Wilkinson *et al*., 2015). Additionally, healthcare

employees can become second victims when they are traumatized by events such as adverse patient care (Richmond, 2018). Importantly, Wilkinson *et al*. (2020) contextualize employee voice in a healthcare setting and propose a framework which integrates synergies between constructive employee voice mechanisms, high quality of care and health outcomes and positive quality of healthcare employees' working lives. In their review of voice in health literature, Hague *et al*. (2024) suggest there is scope to focus more on employee voice and outcomes in addition to advocating for patient care.

McKearney *et al*. (2023) considered how the cultural dimensions which Kwon and Farndale (2020) identified as influencing norms in organisational voice apply in non-western contexts. They found that high power distance cultures in the Asian context of Thailand resulted in conformity and general deference to authority which deterred employee voice, especially upward communications. We might assume that multi-level promotive voice, i.e. suggestions for new ideas (Liang e*t al*., 2012) and prohibitive employee voice, i.e. communicating concerns about actual or potential harms (Van Dyne *et al*., 2003), can improve organisational outcomes. Yet how can this be achieved in high power-distance contexts where there is a significant reliance on foreign workers and where employee voice is likely to be stifled despite national transformation plans as in the Saudi context? If culture trumps strategy (Merchant, 2011), how will Saudi Arabia achieve its ambitions if employee voices are stifled? Clearly, a different mindset is required.

Our research question focuses on an understanding of intersectional voice inequalities and culture care theory in the case of palliative care nurses in Saudi Arabia. Our insights are helpful to illustrate multiple sources of disadvantage in ageing societies where death and dying need to be addressed more openly. Voice inequality challenges are evident in a high power distance context where religious differences exacerbate marginalisation for foreign and female workers (Rodriguez and Scurry, 2019). The context of palliative care provides a particularly interesting context for reflections on intersectional employee voice inequalities in a sensitive scenario which will increase in prevalence in ageing societies.

This paper first outlines the Saudi context and defines palliative care (PC). It then reviews literature on employee voice, nurses, and PC in the Kingdom using culture care theory (CCT) (Leininger, 1997, 2002). Finally, we discuss implications for practice, recommendations, limitations and future research.

The Saudi Arabian context and palliative care

Saudi Vision 2030 presents an interesting case for health transformation. The vision is based on a vital society, a thriving economy, and an ambitious nation. The Kingdom is increasingly using sport and tourism as sources of soft power politically despite its reputation for authoritarianism (Ettinger, 2023) and lack of empowerment in other domains. In a national healthcare context like the Kingdom of Saudi Arabia (KSA) with high numbers of foreign nurses (i.e. work visas sponsored by Saudi organizations) and a high power-distance culture, there are particular challenges related to intersectional voice inequalities with serious implications for the well-being of patients and nurses themselves. Moreover, migrant workers are subject to the control of employer and state sponsorship which limit their mobility (Hammer and Adham, 2023).

Most nursing professionals in KSA are expatriates (Falatah and Salem, 2018). In 2018, the Kingdom employed a total of 184,565 nurses of whom only 70,319 (approximately 38%) were Saudi citizens. Foreign nurses (non-Saudi citizens) are predominantly Indian, Filipina, and Malaysian (Alluhidan *et al*., 2020). There are relatively low numbers of local nursing graduates, just 11 per 100,000 people in KSA compared with 77 in Australia (Alluhidan *et al*., 2020). Over 80% of local nurses are women and they prioritise family over a nursing career (Alluhidan *et al*., 2020). As Saudi diploma nurses (75% of the total) were re-classified as

technicians under the Nursing Practice Act 2020, which restricted them from directly delivering nursing care, there is increasing reliance on foreign hires (Alluhidan *et al*., 2020). There are particular shortages of trained nurses in palliative care in KSA (Zeinah *et al*., 2013), with foreign nurses filling most advanced and specialised care nursing positions (Alluhidan *et al*., 2020). Miligi *et al*. (2019) found that 98% of PC nurses are expatriates. Typically, they have only two to three years' experience because of high levels of turnover, low job satisfaction (Falatah and Salem, 2018), stress, lack of social support (Al-Mansour, 2021), and poor leadership (Alilyyani *et al*., 2022).

Saudi Arabia scores highly on Hofstede's (2011) power distance index. This means that people accept a hierarchical order where everyone has their place. Hierarchy in organisations is seen as reflecting inherent inequality. Dai *et al.* (2022) found that high power distance beliefs hinder communication in the workplace and reduce communication with superiors due to fear of authority. This is demonstrated by a long-term commitment to members of the group, whether it is the family, extended family, or extended relationships. In a collectivist culture, loyalty is paramount and overrides most other social rules and regulations. It is a society that fosters strong relationships where everyone is responsible for the other members of their group. Organisations in high collectivist cultures limit the use of voice channels (Kwon and Farndale, 2020).

The World Health Organization (WHO) (2020) defines palliative care as "an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness." WHO (2020) recognises the physical, psychological, social and spiritual challenges associated with palliative care, including for the quality of caregivers' lives. There are multi-dimensional challenges in talking about the spiritual aspects of care which are integral to an individual's sense of reality (Asgeirsdottir *et al*., 2013). Nurses must accommodate a patient's spiritual needs in end-of-life care (Holyoke and Stephenson, 2017). Cultural congruence helps to enable the most effective end-of-life care (Gysels *et al*., 2011), however, in high-power distance contexts open discussions about sensitive issues such as palliative care between foreign employees and local families and physicians may be particularly challenging.

Literature review using the lens of culture care theory

We used a narrative literature review to gain familiarity with existing literature in a specific social context (Juntunen and Lehenkari, 2021) related to employee voice, nursing, and palliative care in Saudi Arabia. This involved iteratively exploring, selecting, critically evaluating, pre-analysing and reading academic articles on Google Scholar to (re)define the focus and research questions then writing key insights. Narrative reviews are valuable to interconnect different topics (Baumeister and Leary, 1997). In this case, we are considering culture care in health literature as well as socio-cultural, organisational and individual employee aspects which influence employee voice. The 31 studies identified were published in English in peer reviewed journals over 18 years from 2006 until 2024 and are asterisked in the list of references. Twelve of the studies used questionnaires, not highly participative research methods to encourage insights into employee voice. There is scope to draw on dyadic interviews (Morgan et al., 2016), for example, and focus groups. Interviews with paired local physicians and expatriate nurses in palliative care would enable researchers to hear voices and stories directly although there may be potential challenges with one person dominating the conversation (Szulc and King, 2022) and a lack of willingness to engage in dialogue.

Culture care theory

In seeking to relate the findings from the literature review to intersectional voice inequalities in nursing, we draw on culture care theory as a useful framework. This emphasizes the

influence of cultural and religious factors on care experiences (McFarland and Wehbe-Alamah, 2019). Leininger's (1997, 2002) transcultural care nursing model for health, well-being or dying provides a holistic, transcultural, humanistic and scientific approach to promoting patient-centred care. By integrating CCT into our discussion on intersectional voice inequalities, we raise questions about tensions in different world views about the nature of palliative care and clinical interventions using technology. These are influenced by culture, kinship, values and beliefs, political and legal positions on the use of opioids to alleviate suffering, and the rapidly growing economic context of Saudi Arabia which remains a developing country despite its huge wealth.

With foreign nurses' different educational backgrounds and limited levels of Saudi public awareness about palliative care, CCT illustrates incongruities amongst "folk care" mentalities, expatriate nursing care expectations, and local medical practices. In terms of managing changes to address gaps in public and professional healthcare worker knowledge, the options to maintain the status quo, to adapt, or overhaul approaches to the foreign palliative care nurse's voice is a critical site. Migrant nurses in particular experience challenges in reconciling national transformation ambitions and local medical leader capabilities and attitudes which may not be progressive in terms of disclosing patients' diagnoses and prognoses in line with family preferences.

What are the human resource development implications, for instance, in developing local medical leaders to support a newly trained Hindu India woman nurse in the Saudi palliative care context? This is especially challenging for migrant nurses' ability to voice concerns about professional ethics when family caregivers and local doctors may decide against disclosing to palliative care patients the realities of their illness or consult patients regarding decisions about (non)treatment.

Macro-level perspectives

Morrison (2023) called for more employee voice research on macro-level contextual factors and this article considers national culture as an important but under-studied aspect in employee voice literature (Kwon and Farndale, 2020). Despite its wealth and ambitious reforms, conservative societal/tribal traditions and family norms in a deeply religious developing country present particular cultural challenges for migrant employee voice inequalities in Saudi Arabia. Socio-cultural, religious, technological, political, legal and educational factors all interact to create intersectional inequalities for migrant nurses.

Saudi national culture is a unique blend of tribal customs and an Islamic view of the world (Almutari and McCarthy, 2012) which can result in culture shock for migrant nurses (Alosaimi and Ahmad, 2016). This is despite the Crown Prince's drive to modernise the Kingdom's conservative society by diversifying from its dependence on oil with initiatives such as improving healthcare and education, allowing women to drive and promoting its culture (Farzeen, 2023).

Migrant nurse employee voice inequalities in Saudi Arabia are influenced by a high power-distance national culture, negative public views on nursing and palliative care, close kinship and family norms which mean that family caregivers may decide whether a patient is told the truth about their diagnosis/prognosis in a folk rather than professional model of care aligned to international professional standards.

Legislation

Saudi legislation which limits opioid prescription (AlShehri *et al*., 2023) is also an issue in managing pain. Migrant nurses are not able to practise non-medical prescribing although they may have had prescribing rights in other countries.

High power-distance national culture
In Saudi Arabia, foreign nurses must contend with high power distance norms where unequal power between individuals in society, family and managing in organisations (Bjerke and Al-Meer, 1993) is acceptable. McKearney *et al*. (2023) found that high power-distance national cultures result in conformity and general deference to authority which deters employee voice, especially upward communications.

Public views on nursing and palliative care
The image of nursing is another cultural constraint on nurses' voices. In Saudi Arabia, nurses lack role legitimacy which challenges the psychosocial and communication aspects of patient care (Aldossary, 2013). In the eyes of the Saudi public, nursing generally has a poor public image and expatriate nurses have weak authority (Alsadaan *et al*., 2021). The public's perceptions about palliative care (Almobarak, 2016) are generally negative and at the same time migrant nurses have limited understanding of death/dying cultural practices, rituals and attitudes about disclosure to patients in the Saudi context.

Kinship, family norms
Professionally trained migrant nurses may be shocked by decision-making which largely excludes patients and favours family caregivers (Al-Shahri *et al*., 2024) in Saudi Arabia. The closeness of extended family members and involvement of family care givers in decisions to the exclusion of nurses' voices despite their proximity to patients can result in nurses' distress about professional ethics.

Folk model of care
Ad hoc family decisions about directives and religious non-intervention beliefs based on letting an illness take its natural course in Saudi Arabia expose nurses to what is called in the CCT framework a 'folk model' of care. This is not based on medical evidence but personal prejudices, stigma, and not wanting to give up hope. Folk models of care persist when there is lack of public and professional awareness about palliative care and processes involved in dying. This is not helped by Saudi nursing students having a low level of knowledge in palliative care (Aboshaiqah, 2020). This means that migrant nurses in the specialty may feel the need to express their opinions based on their higher levels of knowledge and expertise. For cultural reasons and given their fixed-term contract status, however, they cannot speak up when they see poor practices because national culture is an important mediator of employee voice in Saudi Arabia (Mohammad *et al*., 2023).

Meso-level perspectives
At the organisational level, migrant nurses' voices in Saudi healthcare are constrained by a lack of employee rights, hierarchical and conservative cultures that favour Saudi citizens, and top-down task-focused communications. There is poor leadership, a lack of training opportunities, challenges in decisions about using medical technology unnecessarily in end-of-life care and workforce shortages cause heavy workloads which add to stress levels.

Employment rights
Saudi Labour Law includes anti-discrimination provisions against unfair treatment based on race, gender, nationality, religion, or disability. Expatriate employees must have valid work permits and residency visas (Iqama). Arain *et al*. (2022) argue, however, that the absence of the voice of migrant workers represents a dark side of supervisor-employee relationships. In practice, your passport determines your pay, with higher salaries and easier working conditions for Saudi nationals while South Asians paid less than westerners (Adham, 2023).

Saudi workplace culture
Discrimination, particularly against migrants from developing countries (Arain *et al*., 2022), reduces teamwork and in Saudi healthcare where nurses lack autonomy which can hinder the quality of care and trust (Alsufyani *et al*., 2020). Aboshaiqah (2020) notes that nurses are viewed in Saudi Arabia as merely subordinating themselves to doctors' orders and patients' needs.

Communications
Communications between local Saudi nursing managers and migrant nurses, between nurses and physicians, and amongst nurses and patients and family care givers are characterised by assumptions that nurses' voices are not included in decision-making. This is especially the case when decisions are made in Arabic and language is a barrier (Alasiry *et al*., 2012). Workplace behaviours that focus on palliative care tasks rather than communications between nurses and patients (Alshehri and Ismaile, 2016) further stifle employee voice in critical care units in Saudi Arabia.

Leadership
Poor leadership (Alilyyani *et al*., 2022) reduces staff satisfaction. Top managers in the hierarchy making decisions without consulting staff about workloads results in reduced discretionary effort, absenteeism, and higher turnover (Adham, 2023). Another problem is passive-avoidant styles amongst Saudi clinical nurse managers (Alluhaybi *et al*., 2024) and exploitative leaders (Bajaba *et al*., 2023).

Lack of training and use of technology
Because of the lack of regular training programmes about communications and evidence-based palliative care, nurses in Saudi Arabia experience difficulties in understanding decisions about advanced directives such as do-not-resuscitate (DNR) orders and using feeding tubes (Alshehri and Ismaile, 2016). This exacerbates a sense of loss of voice and ethical concerns for nurses, in particular at the point of death when physicians may avoid families (Abu-Ghori *et al*., 2016).

Workforce shortages
Clearly, problems with recruitment, cultural diversity, Arabic language, discrimination, retention, wages, and challenging working conditions challenges (Alsadaan *et al*., 2021) exacerbate workforce shortages and nurses' not feeling they have a voice. Low job satisfaction (Falatah and Salem, 2018), stress, and lack of social support (Al-Mansour, 2021) can become a vicious circle in adding to workload intensity.

Micro-level constraints on employee voice

Gender
In terms of individual characteristics which influence employee voice, clearly in a patriarchal society like Saudi Arabia, gender is a key disadvantage for women nurses. There are restrictions on women nursing men and there are high levels of turnover intention for foreign women nurses (Alreshidi *et al*., 2021).

Age
Age can be a benefit as Daheshi *et al*. (2023) observed that more qualified and experienced nurse supervisors had better perceptions of nurse-physician communications. It is likely given

the lack of formal communications channels that 1-1 informal conversations work best in a very hierarchical society.

Race/ethnicity/developed or developing country nationality
Racism against foreign nurses is likely to be higher for those who originate from a developing country such as India or Pakistan where women nurses are not expected to speak up.

Religion
On the other hand, religious differences can cause significant culture shock for non-Muslim nurses in Saudi Arabia (Alosaimi and Ahmad, 2016; van Rooyen *et al*., 2010). Alshammari *et al*. (2019) found a lack of understanding and, in some cases, disrespect for patient's religion amongst migrant nurses. Nurses need to understand Islamic principles to deliver culturally competent care (AlYateem and Al-Yateem, 2014).

Spirituality
Moreover, given the nature of end-of-life care, spirituality care is essential and may be another area which migrant nurses feel ill-equipped to speak about. Khraisat *et al*. (2019) argue that the best facilitators believed in spirituality when listening to patients and it helped them find peace. If nurses lack this capability, this may add to their stress levels and feelings of marginalisation.

Language fluency in Arabic/English
Self-evidently, nurses whose first language is not Arabic or English may experience specific voice challenges. Limited nurse–patient communications can negatively affect patient safety and satisfaction (Alshammari *et al*., 2019) despite the availability of local interpreters as these are unlikely to have any in-depth appreciation of palliative care.

Family trust
Migrant nurses in KSA need to appreciate the focus on family and kinship and can feel frustrated and stressed by how family members intervene in the nurse–patient relationship by increasing emotional labor and making communications a constant battle (Halligan, 2006). It is difficult for migrant nurses who are not expected to voice their opinions about advance directives or treatment plans to feel that they are building trusting relationships with family members.

Expert knowledge
As local nurses tend not to be knowledgeable about international standards for palliative care (Douglas *et al*., 2011), migrant nurses' feel devalued for not being able to speak about their experiences of countries with much better developed hospice and community/at home palliative care. They can be especially frustrated by the lack of medical prescribing rights for nurses in KSA.

Personal resilience
Faced with multiple factors that stifle their voice, migrant nurses must develop coping strategies to sustain personal growth despite heavy workloads (Chetty *et al*., 2021) and shifts which can lead to overload and burnout.

Based on these insights, Figure 1 provides an overview of macro, meso, and micro level challenges that impact foreign female nurses' experiences of intersectional voice inequalities. Conflict arises between traditional societal/tribal beliefs about families knowing confidential information about a patient's condition which requires palliative care and not disclosing this to the patient. There are challenges linked to local physicians' reluctance to disclose information

and foreign nurses' close proximity to patients. Nurses from backgrounds where they are used to being outspoken feel that they should professionally disclose diagnoses, however, this may result in their work visas being terminated, for instance when they take annual leave. Different world views and high power-distance in a hierarchical society where local physicians' voices silence foreign nurses can exacerbate workforce shortages. In the under-developed speciality of palliative care where there are few local nurses and physicians this can lead to unnecessary suffering.

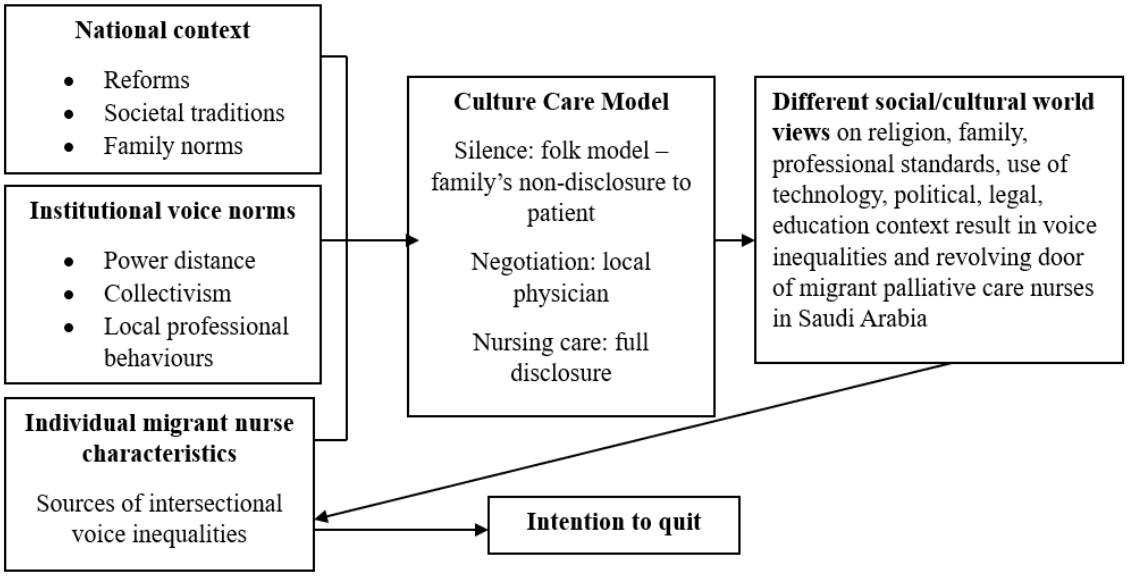

Figure 1. Integrating intersectional voice inequalities and the culture care model

In summary, in considering intersectional inequalities in the Saudi palliative care context for migrant nurses, the following categories are noted in the literature: gender, age, ethnicity, religion, language, occupational status, pay and working conditions, class. These create overlapping voice inequalities amongst employees from different national cultures in palliative care health settings where the patient voice is also frequently unheard in discussions about advance directives and continuity of care when care may be futile despite the family's hopes.

We can conceptualize intersectional inequality applied to the case of foreign nurses drawing on Knoll *et al*.'s (2021) insights into how power distance and collectivism in institutions constrain individual voice. We can also reflect on incongruences between leaders' and subordinates' power distance values (Guzman and Fu, 2022).Clearly, non-disclosure of patients' terminal conditions can impact a foreign nurses' feelings of psychological safety and status and their ability to speak up (Bienefeld and Grote, 2014). Inadequate employee voice in the healthcare sector has been associated with high staff turnover (Van Gramberg *et al*., 2020) which exacerbates shortages of nurses and stress levels.

Porter and Teisberg (2006) introduced the idea of value-based healthcare (VBHC) to add value for the patient by defining the ratio of outcomes to costs. The World Health Organization (2021) adopted a broader definition in terms of an in-depth understanding of what communities, families, health professionals, patients, and societies value most in health care in addition to value for money. In the context of palliative care and VBHC, Heo *et al*. (2022) emphasize the importance of patients' rights to self-determination about not prolonging suffering in intensive care. In addition, palliative care patients who are mentally able should be consulted about technical issues in relation to discontinuing toxic treatments, their values about preferences for dying at home/in a hospice rather than in a hospital, do-not-resuscitate orders,

and the benefits of being treated by specialist palliative care multidisciplinary teams that collaborate and integrate healthcare and social welfare services. In their scoping review, van Staalduinen *et al*. (2022) found that education is most frequently cited as the main strategy to implement VBHC. Our review of extant literature suggests that VBHC is not being achieved in Saudi Arabia because of cultural constraints on foreign nurses', physicians' and patients' voices.

Trade unions (Burdin and Kato, 2022) are a conventional mechanism for channelling employee voice, however ,facilitating employee voice mechanisms via formal unions (Freeman and Medoff, 1984) is not an option in the Saudi context as trade unions do not exist. Drawing on literature on employee voice in Saudi Arabia, our contributions concern the challenges of women's voice self-efficacy (Taiyi Yan *et al*., 2022) and migrant worker status (Jiang *et al*., 2018) despite espoused ambitions of national transformation amongst the health workforce and in new models of care. In doing so, we apply the model of culture care theory from nursing literature to develop cross-cultural intelligence (Jiang *et al*., 2018) competences within the medical and nursing workforce. This offers a reflexive and emancipatory approach to supporting dialogue and mitigating moral injury and distress felt by healthcare workers when difficult decisions are being made about patients in distressing circumstances.

Religion defines a worldview of health and disease (Galanti, 2004). Historically, end of life care has been considered a family duty within KSA. Chamsi-Pasha and Albar (2017) attribute this to societal values, norms and customs, and the fact that multi-generational families live together. This has meant that formal palliative care has had relatively low acceptance rates by Saudi citizens (Steinberg, 2011). Chamsi-Pasha and Albar (2017) describe perceptions of palliative care as a potentially harmful treatment. Osman *et al*. (2017) argue that formal accreditation has helped medical professionals recognise and understand the importance of palliative care.

However, Abudari *et al*. (2014) argue that nurses have a knowledge deficit in palliative care. Aboshaiqah (2020) recognises poor levels of palliative care knowledge among nurses within KSA. Osman *et al*. (2017) reported that there was only one nurse teacher in palliative care in 2017. This limits the representation of nurses in the educational system and thus further constrains their voices in this specialty (Boddy, 2013).

Historically, there has been a negative bias towards nursing, particularly for women (Mobeireek *et al*., 2008). The Saudi Commission for Health Specialities Palliative Medicine (2018) states that nurses are often viewed as peripheral members of teams and subordinate to other professionals. As the global centre of the Islamic faith, KSA faces unique challenges in palliative care due to its predominantly Muslim population (Aboshaiqah, 2020). In Islam, there is an understanding that medical treatment and care have limitations (Malek *et al*., 2018). Nevertheless, a Fatwah established in 1989 states that if three knowledgeable and trustworthy physicians agree that a patient's condition is beyond hope, life-support machines can be withdrawn without the patient's family's permission (Hafez *et al*., 2022).

Miligi *et al*. (2019) found that 18.8% of palliative care nurses in KSA reported high stress levels. A lack of acknowledgment can contribute to feelings of frustration and demotivation among nurses (Miligi *et al*., 2019). Nurses working in KSA must understand the culture and religion to provide palliative care effectively (Almobarak, 2016). Yet there is limited information available about overseas nurses' knowledge levels (AlYateem and Al-Yateem, 2014). Van Rooyen *et al*.'s (2010) study conducted in Saudi Arabia revealed that a significant portion of nurses lacked sufficient knowledge and experience of Islam, which hindered their ability to deliver culturally competent care (Leininger, 2002). Many nurses recognized the need for knowledge about the culture and religion of their patients but felt that this knowledge was inadequate (Van Rooyen *et al*., 2010). Yaseen *et al*. (2021) found particular barriers to women

Muslim student nurses caring for male patients. There are clearly challenges for non-Muslim nurses caring for Muslim patients (Abudari *et al*., 2016).

Nurses experience challenges in verbal communication and non-verbal communication cues such as eye contact and touching, due to cultural restrictions (Almobarak, 2016; AlYateem and Al-Yateem, 2014). Saudi nursing students have a low level of knowledge in palliative care (Aboshaiqah, 2020) and the Kingdom has highly restrictive policies about pain medication as there are concerns about opioid addiction and misuse (AlShehri *et al*., 2023).

Silencing nurses who experience particularly stressful situations in death and dying is unhelpful. Wilkinson *et al.* (2024) observed in an Anglophone context the importance of understanding employees' awareness of an organisation's formal voice system and non-designated voice platforms which may be invisible or inaccessible. In contrast, in a national healthcare system context like Saudi Arabia, national culture and social norms in the region require a deep appreciation of reconciling incongruities and inequalities when conceptualising employee voice.

KSA palliative care nursing presents an interesting case study to explore employee voice given the high numbers of expatriate nurses and cultural differences between foreign nurses and patients and their families. Cultural practices and rituals about death and dying present particular challenges for foreign non-Muslim healthcare practitioners' voice because of local religious sensitivities. Professional interpreters can facilitate open communications (Douglas *et al*., 2011) but they also need to be trained to understand palliative care. Cheraghi *et al*. (2005) emphasize the importance of nurses understanding spiritual care needed for Muslim patients to accept death patiently, with prayers and meditation.

Implications for practice

We propose that cultural incongruity in decision-making affects the quality of healthcare workers' lives in ethically challenging specialties such as palliative care. We argue that a culture of care must extend to employees based on greater respect by the public and physicians for the voice of the nurse with wider implications for public communications, line management, systems and leadership development. Institutions must recognise the emotional toll that death and dying takes on clinicians (Sorensen and Iedema, 2009) and the need to support nurses in dealing with emotional labour (Sawbridge and Hewison, 2013). Nurses in KSA are leaving the workforce en masse for various reasons (Alilyyani *et al*., 2022).

Recommendations

Several mechanisms can be adopted to improve employee voice amongst palliative care nurses in KSA. These include encouraging feedback, adopting collaborative decision-making approaches, developing intercultural communication capabilities, promoting greater respect for the nursing profession, and embedding high-quality continuous learning and development in palliative care nursing. Empowering nurses and amplifying their voices can be challenging in the healthcare sector (Alsufyani *et al*., 2020). Nursing staff must be empowered to ensure appropriate decision-making in the right place at the right time (Alsufyani *et al*., 2020). This will promote nurses' engagement with shaping healthcare policies. Structural empowerment can improve staff competency resulting in enhanced workplace dynamics, effective workplace communication, and improved patient care outcomes (Falatah *et al*., 2022). Nurses are often recognised as being better informed about patients than doctors (Silbermann *et al*., 2013). Quality improvement initiatives allow nurses to collaborate with physicians in research or to develop their own evidence-based practice, quality improvement, or research project (Silbermann *et al*., 2013). Interventions can be adopted such as Schwartz rounds which promote healthcare worker well-being in Anglophone countries (Ng *et al*., 2023). Preceptorships can also help expatriate nurses in KSA to adapt to local norms (Mazibu *et al*.,

2024). Hameed et al. (2020) stress the value of managers using Islamic work ethic to facilitate employee promotive and prohibitive voice amongst local workers.

The most frequently cited concern by end-of-life patients is that their cultural and spiritual needs are barely addressed (Abu-Ghori e*t al*., 2016) if at all (Herlianita *et al*., 2018; Tirgari *et al*., 2013). There are also issues about nurses' concerns related to futile care (Mani and Ibrahim, 2017). It is crucial to promote the palliative care nursing profession to provide better treatment and healthcare facilities in a culture where nurses feel heard and recognised (Alzemi, 2021). More training programmes for palliative care are required (Almoajel, 2020) to complement one initiative in primary care (Chowdhury *et al*., 2021).

Overall, our review indicates the importance of migrant nurses in Saudi Arabia receiving appropriate on-boarding briefings to understand local legislation, high power-distance national culture, negative public views on nursing and palliative care, and very close family relationships which neglect nurses' voices in a folk model of care. We recommend that migrant nurses and others who are considering working in the Kingdom talk with workers already there about how their ability and willingness to speak up will be severely constrained by their employment rights, Saudi workplace culture and relationships, hierarchical and task-focused communications, weak leadership, a lack of training and understanding about using technology in end-of-life care in the context of significant workforce shortages. The Saudi Nurses Association, established in 2018, could be proactive in improving standards of nursing and respect for nurses as well as support for migrant nurses. Importantly, the effects on employee voice of discrimination related to gender, age, nationality, race, ethnicity, religion, spirituality, migrant status and occupation all need to be addressed if improvements are to be made to enable migrant nurses' voices to be heard in support of Saudi Vision 2030. On-boarding for migrant nurses can take account of language fluency in Arabic/English, issues of patient family trust, varying levels of expert knowledge about palliative care in the Kingdom, and how psycho-social support and appropriate working conditions can enable personal resilience amongst migrant nurses.

Limitations and future research

While this review highlights multiple sources of discrimination which impacts overseas nationals' employee voice and integrates culture care theory, it is subject to several limitations. As there are very few studies and papers published on this topic, we may be subject to confirmation bias towards what is already known (Schumm, 2021). The literature reviewed was of cross-sectional studies written in English about employee voice in Saudi Arabia and did not include grey literature written in Arabic.

Future research could investigate how successful the initiatives proposed drawing on the cultural care model might enhance the attractiveness of palliative care nursing as a profession in KSA. These insights would further inform evidence-based communications, training, and incentives to attract and retain local and expatriate palliative care nurses to enhance patient care and nurses' voices and nurses' working lives. Longitudinal comparisons in studies with larger samples based on qualitative interviews and focus groups with different types of overseas nurses would provide useful empirical evidence to indicate changes over time as KSA moves from strategy formulation to implementation.

Nevertheless, this current paper provides a foundation for those who are responsible for or interested in addressing intersectional voice inequalities in rapidly developing non-western contexts in complex sectors like healthcare. Line managers can better engage healthcare workers of different nationalities by developing better transnational cultural competences in clinical education and multi-level leadership development for appropriate employee voice mechanisms to mitigate intersectional employee voice inequalities.

Conclusion

We contribute to employee voice research by drawing on theories related to workplace intersectionality (Rodriguez, 2024) and culture care (Leininger, 1997, 2002) from macro, meso and micro level perspectives. We add to literature looking at national cultural factors influencing voice (Kwon and Farndale, 2020) in a non-western context, building on McKearney *et al*'s (2023) study in Asia.

This paper offers unique insights into intersectional voice challenges in the under-researched setting of Saudi Arabia which is mid-way through an ambitious national transformation programme. It is the first time a study has explored the link between CCT and nursing retention through the lens of employee voice and national culture. It is also the first time a study has been conducted on employee voice within the Saudi palliative care sector.

Importantly, unless action is taken to improve employee voice, the palliative care sector will continue to fail to attract appropriately qualified nurses in Saudi Arabia. The effective implementation of the recommendations we propose will assist with the Kingdom's health transformation programme in an emerging specialty. The Kingdom, patients and individual employees will all benefit from palliative care nurses gaining a voice and fully contributing to leadership positions throughout the healthcare system. The gap between theorising and operationalising mitigations to reduce intersectional employee voice inequalities is significant in the Saudi context and may take several generations to address.

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