

A Heideggerian Hermeneutic Phenomenological Research Study into Romanian Nurse Managers' Occupational Stress in UAE

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Abstract: The purpose of this study was to explore occupational stress as perceived by Romanian Nurse Managers working for at least 1 year and a half in private hospitals in Abu Dhabi, UAE. Through, a hermeneutic phenomenological approach, the study aims to illuminate the lived work stress experiences pertaining exclusively to this population and the research findings might not apply elsewhere. Data collection was carried out by employing in-depth, semi-structured, face to face interviews with each participant, after gaining the participant's consent and guaranteeing to respect their privacy and anonymity. The findings of the study suggested that Romanian nurse managers considered their job increasingly stressful and more challenging than back home. They perceived occupational stress as a complex phenomenon, linked to four major themes: organizational factors, workload, interpersonal relationships, Abu Dhabi, a stressful workplace.

Key words: Heideggerian hermeneutics, phenomenology, nurse manager, stress, occupational stress

INTRODUCTION

Although, stress at research is by no means a new phenomenon or a new research topic, concerns about it seem to be steadily rising as stated by National Institute of Occupational Safety and Health (NIOSH) in 2007. Different professional bodies such as the Occupational Safety and Health Agency (OSHA), the National Institute of Occupational Safety and Health (NIOSH), the International Labor Office (ILO), the Health and Safety Executive (HSE) and the National Health System (NHS), media, trade unions and a growing number of researchers have highlighted worldwide the high cost occupational stress has in human (Heyns *et al.*, 2003) and financial terms (Ball, 2004) and have developed different workplace stress prevention initiatives in an attempt to deal with what Raymond called "the Real Millennium Bug".

Stress at research is acknowledged as affecting a growing range of occupations. University of Manchester, Institute of Science and Technology includes nursing amongst those jobs that exceeds the rate of six on a stress rating scale from 0-10 (Di Martino, 2000). Work stress in nursing was first scrutinized during the mid-1950s, when Menzies discovered four sources of anxiety among nurses: patient care, decision making, taking responsibility and change. Since then, nurses' stress have received increasing attention, the early interest manifested by a theorist like Dewe (1987), Benner and Wrubel (1989),

Boey (1998) perpetuating till date when a wealth of literature reconfirms that nursing remains indeed a stressful profession (Shirey, 2004, 2006; Lindholm, 2006; Wu *et al.*, 2007).

As the literature did not reveal previous systematic research into expatriate nurse managers occupational stress, this study comes to explore the way in which these professionals perceive stress at work. A hermeneutic phenomenological design informed by the Heideggerian tradition (Heidegger, 1962) was used to capture the essence of their experiences. The choice for this approach was based on the belief that occupational stress is a subjective phenomenon contextually bound that can not maintain its essential features if scientifically quantified (McVicar, 2003). Phenomenology arose out of German philosophy assuming that reality is multiple, subjective and mentally constructed by individuals (Crossan, 2003). Phenomenological inquiry aims to capture the "lived experience" or the "life world" of study participants (Van Manen, 1990) with the goal of creating meanings and achieving a sense of understanding (Wilson and Hutchinson, 1991).

Despite several reports revealing high work stress level for staff nurses, there are remarkably fewer studies focusing on nurses in managerial positions and no studies could be found on expatriate nurse managers. As a key component of the nursing workforce, nurse managers hold a vital role. They are accountable for the satisfaction of both patients and staff (Hurley, 2007), bear

enormous accountability for their organization success or failure as they influence the use of assets and the patient outcome (Judkins, 2004), provide leadership, continuous direction and support to subordinates and improve staff morale and retention (Mathena, 2002). Moreover, working across borders might prove challenging as the cultural factor could be taxing for any manager working abroad (Jassawalla *et al.*, 2004).

This modest naturalistic research study investigates qualitatively occupational stress as perceived by Romanian nurse managers working in private hospitals in Abu Dhabi, United Arab Emirates.

Review of the literature: The search was guided by the following terms: stress, distress, occupational stress, burnout, nurse manager, head nurse, matron, nurse administrators and expatriate nurse. The first search did not produce any relevant results. Consequently, the term “expatriate nurse” was removed and a second search was performed. The list of studies obtained as full text was screened as most studies referred to the staff nurse role. Seven studies referred to nurse managers, none of them related to expatriates. The studies explored research stress from a variety of angles, comparing studies being difficult, as measures of stress, type and the composition of the research population varied widely.

Yung *et al.* (2004) conducted a controlled study on sixty five nurse managers in Hong Kong exploring the impact of relaxation training methods on their mental health status. As many managerial responsibilities for health care delivery were transferred to unit nurse managers due to power decentralization, their work stress increased. Distress symptoms reported by nurse managers seemed above the published norm. As stress management training programs did not appear to target this population, the researches explored the effect of two relaxation methods (the stretch-release relaxation and cognitive relaxation) on these nurses. Results suggested that both methods resulted in lowering anxiety and improved participants mental health status.

Another study in China investigated the relationships among workplace stressors, ways of coping and the mental health of ninety two Chinese head nurses (Xianyu and Lambert, 2006). The researcher found that the role of head nurse was multifaceted and difficult, multiple responsibilities leading to work overload. The main stressors identified by Xianyu were short-staffing, workload, conflict with physicians and death and dying. The most frequent coping strategies were self control, positive reappraisal and proactive problem solving.

In Sweden, Lindholm (2006) conducted a quantitative comparative study to investigate work stress in nurses in

chief managerial positions and physicians in clinical director positions. Both groups carried out their commitments in a very demanding work environment described in terms of political decisions, organizational changes and financial constrains. High job demands and ineffective support systems were found to be the main occupational stressors in these populations. Lindholm suggested that job demands have increased to such an extent that it is unlikely to be buffered within common supporting methods. The researcher proposed that job demands must be decreased while initiatives of identifying the right kind of support for particular research situations must be taken.

In the United Kingdom, Rodham and Bell (2002) performed a qualitative study to investigate perceptions of stress on female junior healthcare managers. They used a combination of critical incident diaries and semi-structured interviews, analyzing data from a grounded theory approach. Rodham and Bell (2002) found that junior health care managers were generally not aware of potential work stressors and the effect they might have on their health and performance. They suggested that a culture of acceptance and expectation of work stress in this group of managers interlinked with a lack of awareness to effectively and proactively manage work stress.

Loo and Thorpe (2004) performed a two-round Delphi study with forty one Canadian female nurse managers, aiming to identify major stressors and recommend healthcare administrators the right support. They scrutinized the changing roles and challenges of first-line nurse managers and found the need to better equip participants for their stressful roles. Management was recommended to provide participants with the appropriate resources and to allow them to spend more quality time in performing their management responsibilities. The need to introduce a more participative management style to empower the nurse managers was also recommended.

A quantitative study was conducted by Judkins (2004) to explore the relationship between hardiness (a variable that alters stress perception and increases coping abilities), stress and coping, in one hundred forty five nurse managers in Texas. Hardy individuals were defined as active, goal-oriented people, approaching life with interest and excitement, seeing themselves not as victims but as active determinants of the consequences of change. The researcher found “high hardy” nurse managers perceiving lower stress than nurses with low hardiness and suggested that hardiness training is necessary to prevent and manage work stress. Hence, staff retention and satisfaction as well as financial bottom line and quality will increase while burnout and turnover will decrease.

Based on the above study, Judkins *et al.* (2006a) conducted a subsequent exploratory study on thirteen nurse managers in Texas aiming to investigate the development of a model hardiness training program and evaluate whether work stress could be reduced. Their study revealed that hardiness training may improve workplace culture as staff and managers would feel increased job satisfaction and may reduce turnover as staff would feel more empowered and committed to the organization.

MATERIALS AND METHODS

The Heideggerian phenomenology recommends a sample that includes those who have experienced the phenomena and can articulate their experiences, therefore, full time nurse managers having at least 1 1/2 years of continuous experience in the current position were selected. The exclusion criteria included nurses who had extended leave during the past 1 year. The sample included 10 Romanian nurse managers employed in private hospitals in Abu Dhabi, United Arab Emirates, at the time of the selection. All ten participants were female, age varied in between 30-50 and all were full time employees, working a minimum of 48 h a week. Out of the whole research population, 40% of the participants resided in Abu Dhabi with their husbands and children, 10% were single parents, 20% had no children and lived in Abu Dhabi with their spouses and 30% were single.

A verbal explanation about the study and what it entailed was given so that participants were well informed to make a choice. Their right to ask for explanation as well as to withdraw from the study at any time was emphasized. Participants' identity was protected through pseudonyms (S, LS, JNN, CS, E2, AM, M, E1, IM and EB). Moreover for confidentiality reasons the name of the organizations were not revealed.

Informal, semi-structured, open ended and face to face interviews were chosen for this study as they allow researchers flexibility in collecting information from the participants. Based on some predetermined questions, semi-structured interviewing offers the possibility of modifying the line of inquiry following up participants' interesting responses and probing further to investigate underlying motives. It also provides richer data allowing participants a greater flexibility to respond to researcher's questions and probes, recounting their experiences without being tied down to particular answers (Minichello *et al.*, 1996).

The duration of each interview varied between 30-45 min, based on Blaxter *et al.* (1996) suggestion that anything under half an hour is unlikely to be valuable;

anything that goes over an hour may be making unreasonable demands on busy participants. Although, the pilot interviews utilized eight open ended questions, each subsequent interview suggested additional ones. Eventually, seventeen prospective questions were included in the guide. The introductory question was "What do you understand through occupational stress?" The next question was "Could you remember any situation when you felt stressed at work?" Thereafter questions were posed according to the lead that each participant has provided. Encouraged to describe their everyday experiences, participants were reassured that no subject is trivial.

To clarify responses that seemed unclear or incomplete thus enhancing participants' description of their lived experiences, the researchers carefully used verbal and non-verbal probing as Geanellos (1999) recommended. "What did you do, feel or think then?" is example of probing questions that researchers commonly utilized. If the participants did not wish to expand, their decision was respected and probing avoided.

Data analysis went hand in hand with data collection, performed around an adapted form of Colaizzi (1978) 's seven-stage process, a method commonly used in phenomenological studies (Beck, 1991; Clarke and Wheeler, 1992).

RESULTS AND DISCUSSION

Four major themes have been identified by data analysis. The first theme was interpreted as "organizational factors", including the lack of policies, the dichotomy between two management aspects the HR and the Director of Nursing (DON) and operational failures created by other departments.

Most participants felt that not having clear policies and procedures to streamline work, reinforce consistency and accountability was indeed stressful. Some participants mentioned policies of patient visiting hours, some of staff leave and some of salary scale:

- CS: policies and procedures are not in place and if they are they are long and boring to read the orientation program has improved incredibly but still not enough (Interview 4, paragraph 19.1, p. 8)
- JNN: Yes this has been big problem here you know not having proper defined guidelines or policies if you don't have the guidelines to how to implement the leave, one department may be saying you can take 2 months annual leave a year, whereas another department may say, no you can take only 3 weeks a year (Interview 3, paragraph 4.2, p. 2)

Not having hospital policies to reinforce the visiting hours was interlinked with security's inability to control non-compliant visitors: E1, E2 and EB expressed their concern of having hospital security guards not empowered to exercise their role. EB who manages a unit having high patient's acuity levels, stated:

- EB: the security comes and reports to you that they (the patients) are not following (rules). They bring in a lot of people from here and there. So that is another stress is really a stressful situation. (Interview 10, paragraph 7.2, p. 3)
- E1: alternatively made an interesting comparison between security provided in her workplace, government hospitals in Abu Dhabi and hospitals in her own country:
 - E1: in our country we follow very strict rules and guidelines for visiting hour. Abu Dhabi Police is based at all government facilities and they can help enforce visiting hours. In our facility, the security staff, support staff is actually not empowered enough to support us (Interview 8, paragraph 18, p. 7)
- E2 added:
 - E2: of course here the security is not of help at all because they can not touch the people. They are not allowed by the law of this country to physically touch them or remove them (Interview 5, paragraph 8.3, p. 3)

As the Human Rights and Labor (2006) mentions instances when expatriates were deported from the UAE for trivial things, researchers' understanding was that security staff tried to avoid confrontations fearing job loss. However, CS pointed that the root cause to this problem was the language barrier:

CS the security department they suddenly change hands; they do not have an idea of what's going on as they can not communicate that is a big stress (Interview 4, paragraph 15.3, p. 6).

Although, English was the business language in these hospitals, some security guards lacked basic English language skills. If security guards were neither fluent in English nor in Arabic their lack of confidence in managing conflicts was probably justified.

Data analysis uncovered two contradictory management aspects, each of them impacting differently on participants' stress. As managerial behavior seems to be linked to stress and burnout (Stordeur, 2001) the HR department portrayed as ineffective, inconsistent and unreliable was perceived as de-motivating and stressful. Six interviewees (S, LS, JNN, CS, E2 and IM) depicted the

HR as a disorganized department that does not live up to nurse managers' expectations being: "terrible", "weak", "biased", "not keeping promises", "without structure", "inconsistent", "culturally insensitive", "unfair" and "de-motivating":

- S: no, I was not pleased. Because in my contract they stipulate an X salary but I did not get that (Interview 1, paragraph 3.4, p. 2)
- E2: i think is terrible because we've been through how many HR managers since I have been here, I think we had four, so there is no structure as we have been promised and the policies and procedures for the past 3 years nothing is on the table yet. it is frustrating (Interview 5, paragraph 23, p. 7)

Two other responsibilities of the HR, the payroll system and the housing were cited as stressful during interviews 1, 2, 5 and 7. S said:

The S, still, some of the departments like our payroll, I am not happy with them. With the HR, like I said, a lot of it is culture too, even the housing culture, you put a person from another country in this position versus no name mentioning, a lot of times our culture sets a different way of living (Interview 1, paragraph 13.2, p. 6).

LS, IM and EB thought alike, frustration sprung from the fact that new staff was better paid than old staff:

- LS: for example, one nurse is taking 10,000 and the other takes 4,000 and you give 10% increase each, the gap does not change at all. It does not help at all. It affects me because I can not do anything. All I can say is sorry I can not do anything. (Interview 2, paragraph 16, p. 10)
- IM: Yes, especially with the scaling that they are doing, the old staff is getting less. The new ones are getting this salary because they are starting at the right amount. When it comes to increments they (old staff) are wondering how they will ever catch up, when the new ones are getting increase as well. Even between the nationalities, old and new, you talk about thousands of Dirhams (Interview 9, paragraph 13.1, p. 4)
- EB: no, they have revised the salary scale and they are ready to I think it has improved much (Interview 10, paragraph 24.2, p. 9)

Most participants revealed that significant stress originated from the HR. The need for HR to create a motivating work climate and build credibility was silently recommended.

Conversely, many participants considered their DON a role model and felt that her open door policy, participative management and transformational leadership skills fostered communication and increased their motivation. Goleman (2001) suggested that employees perception of work climate is actually linked to the character of the leader and these type of leaders help retain staff and gain competitive advantage for their organization (Stordeur *et al.*, 2001; McGuire and Kennerly, 2006):

- LS: you see a lot more humanity expressed; you know care for the staff It's so much nicer now (Interview 2, paragraph 15.3, p. 9)
- EB: there is a lot of importance given to nurses here the image has changed. One of the reason is our nursing director. She is very supportive open door policy (Interview 10, paragraph 14.2, p. 7)
- E2: at least we've got now 300% support from the management (Interview5, paragraph 9, p. 3)
- IM: the management is very nice, especially in the nursing side, so that makes the things less stressful because you have somebody to turn to (Interview9, paragraph 21, p. 7)
- E1: for the past 3 years we had a good nursing management team and that subsequently has filtered down through the nurses and the doctors and the whole hospital sees that we are a good team and therefore, we are regarded as professionals as we should be (Interview 8, paragraph 12.5, p. 5)

LS demonstrated deep empathy when she portrayed her DON as a woman manager struggling in a male dominated society: LS, she probably needs a little bit more support because she is alone; her position is a very lonely position apart from her there is no other female in the senior management team is not an easy thing to be in a male environment and she does it well (Interview 2, paragraph 15.1, p. 9).

Research suggests that operational failures occur with regularity in complex service organizations (Tucker, 2004) and learning from failures seem to be difficult for most companies (Carroll *et al.*, 2002). This probably explains why most respondents perceived operational failures as chronic stressors, compromising the work flow and quality of patient care:

- E1: i think that the people you actually work with don't actually understand the implication of the position and the stresses it does have in it (Interview 8, paragraph 3, p. 1)

- CS: you are absolutely left over to the support services of the hospital If you need something urgently people do not understand what the nursing practice needs on the whole and then it can be very stressful (Interview 4, paragraph 4, p. 1)

Problems with the materials department, biomedical engineering, information and technology, finance and billing, pharmacy and laboratory departments were mentioned.

Participants implied that unless these departments function properly the nursing department can not act. The greatest frustration was created by the shortage and/or poor quality of some materials:

- EB: the same (stress) with supply and stores is out of stock, it is not available in the UAE, it takes long for shipment that also puts a lot of stress on you and this takes a lot of time from us also following up and calling and writing e-mails and sending letters and involving our superiors (Interview 10, paragraph 10, p. 5)
- CS: products must be of a high standard consumables, equipment, everything must work properly if it doesn't work properly you can't carry out your tasks accurately and promptly and make the patient happy (Interview 4, paragraph 18, p. 8)

What participants considered highly stressful was the lack of communication and feed-back from other departments:

- E2: you are waiting ages and if you don't follow up trough yourself you will never get the things (Interview 5, paragraph 24, p. 7)
- JNN: if something goes out of stock you can't just get it in 24 h later. So there are a lot of limits; sometimes I feel they use it as an excuse and you are just left waiting for 2 years (Interview 3, paragraph 10.1, p. 4)

It was interesting to observe the different views participants had on the biomedical engineering department. EB and E1's accounts reflected the dichotomy:

- EB: for example, you give your equipments for repair and then is taking long time to come back or there is no feedback, you just keep on calling to find out and then they will give an excuse and these are really giving us stress. (Interview 10, paragraph 10, p. 5)
- E2: i have no problem with biomedical engineering. I think they are following up on the problems quickly

and they are solving as soon as they can and at least they provide some feedback (Interview 5, paragraph 26, p. 7)

E1 and M explained an interesting strategy to get things done on time by using influence and authority. Both participants suggested that things move faster when the senior management is aware of a request:

- E1: I cc: everything to the DON (laughs) (Interview 8, paragraph 19.1, p. 8)
- M: if you push it through the senior management the work is done very well in this place (Interview 7, paragraph 6.2, p. 3)

Insurance, billing and the discharge departments were also perceived as stressful by two respondents CS and M who felt that the patient turnover would increase if these areas will maximize their efficiency. CS: i mean you just think about the discharge process in this hospital is much too long. We can fill a bed sometimes three times in the mean time the people working at the insurance department and the billing and the discharge people are just not quick enough, efficient enough or know what they are doing (Interview 4, paragraph 19, p. 8).

A common theme surfacing during data collection was the “workload”, presented either in relation to the complexity of participant’s role, the effort of improving quality or the home/work interface. Research studies on staff nurse pinpointed workload as a major stressor (Demerouti *et al.*, 2000; McGowan, 2001; Greenglass *et al.*, 2001; Hall, 2004; Judkins *et al.*, 2006b). Workload was associated with a variety of harmful psychological symptoms, including burnout depression, anger and cynicism (Greenglass *et al.*, 2003). Judkins *et al.* (2006b) affirmed that contemporary Nurse Managers “are expected to do more with fewer resources while maintaining quality standards and are expected to achieve contented staff, that neither burn out nor turnover”. The current complexity of nurse managers' role has been acknowledged worldwide (Loo and Thorpe, 2004; Judkins, 2004; Yung *et al.*, 2004; Lindholm, 2006; Xianyu and Lambert, 2006).

Although, all the participants mentioned the complexity of their role JNN, EB and IM offered probably the best description of the extent to which workload affected them. Although, JNN considered stress “a good motivator in getting the things done” she highlighted the negative aspect of stress related to workload: JNN; when everything was happening at once, I was trying to get ready for going on leave, it felt like oh and the management project and it just felt that there was too

much and then that becomes dangerous (Interview 3, paragraph 22.1, p. 8). IM and EB shared the feeling:

- IM: it is very stressful because you have to do everything. The nurse managers in this hospital are expected to run the whole unit entirely as separate from the other units, everything from patients to the staffing and everything else (Interview 9, paragraph 3, p. 1)
- EB: now a days the things are getting a little bit you know stressful there are a lot of standardizing committees, quality and quality assurance and there are a lot of things that you really have to keep pace with (Interview 10, paragraph 3, p. 1)

E1 on the other hand, felt that being pressurized to shift priorities and having to accept extra work without additional human resources was very stressful. E1: it was put to us that we have to train so many people in a very limited period of time, increasing our work hours tremendously, increasing our resources tremendously and tasking us away from our other areas of work that we need to be able to do. So that was a tremendous stress for me (Interview 8, paragraph 4, p. 1).

Short staffing was mentioned by EB as well who although did not like to request her nurses to work overtime she had to in order to cope with workload.

Asked of how they balanced between life and work, most participants acknowledged the importance of disconnecting and keeping the two spheres under control. However, they admitted that a firm boundary between work and life was not possible. Data revealed that although, participants struggled to separate work and personal life, they either partially or completely failed, a variation in participants' ability to juggle the two being observed:

- JNN: well, I think that one has to have a balance, you know. I have a son at home, so the minute I get home I take off my work, I put it away as much as I can (Interview 8, paragraph 2.1, p. 8)
- LS: i don't take stress home yes sometimes I take home and I dump it on my husband. It's rare but sometimes it happens (Interview 2, paragraph 13, p 8)

Although, these participants seemed to succeed once back home to relatively detach themselves from office burdens, others felt that the amount of work they have to complete can not be achieved within their duty hours:

- E2: the amount of work and I am not sleeping enough; taking work back home because you don't have time in the day (Interview 5, paragraph 17, p. 5)

- M: a lot of stress and when I will go home I will still be thinking about that staff (Interview 7, paragraph 8.5, p. 5)

Participants seemed to perceive stress as a never ending problem, a continuum from work to home and work again. This supports the claims made by Hurley (2007) who argues that workplace stress and personal stress are not mutually exclusive. This was probably best reflected by M, who described a circle of stress, frustrations being brought back and forth in between work and home. M: at work I have too much stress; at home also I do not have rest next day come again for duty, so every day and night life is full with the stress (Interview 7, paragraph 13, p. 7).

Owing to multitasking, we expected all the participants to face significant work stress. In fact, one nurse manager, assigned mainly to supervisory night shifts did not seem overwhelmed with work, contrary she felt stressed when workload diminished, resulting in monotony. Considering her feeling uncommon we found out that her perceptions were in fact natural, studies demonstrating that when a person's resources are underutilized, stressful situations might occur (Motowildo *et al.*, 1986).

"Interpersonal relationships" was a theme encountered in all participants' narratives. Nurses were concerned with three major factors: managing multicultural teams, the physician-nurse conflict of values and the patient as an eternal VIP. The culture factor surfaced in participants' accounts, working in a multicultural environment being perceived as challenging. Wilson found that nurses have reported feelings of helplessness in effecting change and discomfort when working with diverse colleagues who were not their own race and culture. Although, workplace diversity seemed valued by organizations, some researchers found negative effects between diversity and performance (Stewart, 2006). In fact, it was suggested that "co-workers are employees' major source of stress".

E2 believed that she was repeatedly misunderstood due to her accent as she was not a native English speaker. Likewise AM could not always understand the accent of some team members:

- E2: many times I have been misunderstood because of my language. English is not my first language and I will use a certain phrase and somebody else will interpret it totally wrong (Interview 5, paragraph 27, p. 8)

- AM: everybody has got different accent, so is not always easy to understand every accent if I don't hear well I ask them to repeat until I understand (Interview 6, paragraph 16, p. 5)

Seven participants (S, CS, E2, AM, M, IM, EB) considered communication a stressful factor. E1 and E2, nurse managers responsible for nursing education shared their stories:

- E2: the background that they've got, they are from different areas of the world and the type of training that they have because in some country training is better than the others. So to bring that together in a department requires such a huge effort (Interview 5, paragraph 5, p. 2)
- E1: here we have to either force staff or bribe staff to go and do their education. The finer majority of the staff don't see the work of a professional nurse as a career, they see it as a job, it's just a job not a career. That's one of the biggest challenges to face is changing the mindset of the staff (Interview 8, paragraph 6.2, p. 2)

E1 thought that adult education should be "70% from the adult and 30% from the educator" (Interview 8, paragraph 6.1, p. 2) and felt that nurses of particular cultures, although given the opportunity to develop, demonstrated a passive approach to learning, expecting to be "spoon fed".

Five interviewees expressed concern with employees' attitude to organizational change. To maintain its leading position in the market the organizations have to implement several simultaneous changes, generating considerable work stress. Stahl *et al.* (2006) while researching diversity-performance link in multicultural teams, found that staff with diverse background, education and experience, hold different belief structures and values impacting on the manner they prioritize, interpret and react to stimuli. This supports some participants observation that Asian and Western nurses prioritize learning in different ways. Stahl's argument also sustains participants perception that staff of different cultures had different views on changing habits and accepting new work standards. However, it was suggested that resistance to change might be a feature of overworked employees and not only a cultural symptom (Melton, 2001). IM: we are going to have to do a lot of changes I don't know if they are going to be accepted by all the people here, especially the old staff they are very reluctant to change (Interview 9, paragraph 19.3, p. 6).

Similarly E2 and JNN explicated their rationale to why staff might be more willing to maintain the status quo:

- E2: i think they are narrow-minded in what they are doing and they are stuck in their positions and they are in their comforts and they are not willing to proceed and to move along (Interview 5, paragraph 4.2, p. 2)
- JNN: unfortunately human nature is that if it involves work or change, they resist it and the resisting is the stress. If they can see the logic behind it may be easier (Interview 3, paragraph 13.1, p. 5)
- E2: i have got a real battling with the doctors because I want things to be improved and my immediate head of department is just stuck. No leeway and no bit of lateral thinking, nothing there is no communication, so at this stage that's a huge stressor in my life (Interview 5, paragraph 6, p. 2)

Nine respondents seemed to have encountered stressful personal experiences with their physicians in terms of: tardiness, incompetence, excessive control and influence, verbal abuses, poor communication skills and rivalry between doctors. Participants felt that some physicians stereotyped nurses as subordinates while nurses believed in partnership.

Sources of conflict between physicians and nurses have been reported long ago. In 1960's the "doctor-nurse game" was described as a stereotypical pattern of interaction in which female nurses learn to show initiative and offer advice while deferring doctor's power (Mikanowicz, 2008). A study conducted by Tabak and Orit (2007) revealed that the doctor-nurse relation was still a significant source of stress for nurses in Tel Aviv. Xianyi and Lambert (2006) found that conflict with the physicians was also a main source of stress for head nurses in China. Mikanowicz (2008) mentions that now a days, nurses and doctors have high expectations of each other.

The most frustrating fact was that some doctors of certain ethnicity were in the habit of shouting and verbally abuse nurses and junior doctors. Studies indicate that verbal abuse impacts the workplace by decreasing morale, increasing job dissatisfaction and creating an unfriendly work climate (Aiken *et al.*, 2001; Cook *et al.*, 2001):

- LS: the approach completely runs on the wrong way. It's the demands, shouting at staff. It is so counter-productive to shout at people because they just get nervous and they make all mistakes (Interview 7, paragraph 6.5, p. 4)

- M: the way she screamed was very unprofessional in front of the patient she is screaming at the staff she is screaming at the doctor at the registrar, telling the patient this doctor is not good, this nurse is not good throwing the instruments telling the doctor 'doctor you go out, I will do my work'. Sometimes they will name the staff 'you are a stupid nurse' (Interview 7, paragraph 8.2, p. 4)

M shared her concerns about doctors temper and nurses feelings, believing that such situations compromised the wellbeing of nursing staff: M; when I will go home I will still be thinking about that staff the strain and stress she carries to the house, she will be dealing with the children and husband so the whole family is affected (Interview 7, paragraph 8.5, p. 5).

The rapport with patients and their families was another stress factor revealed by respondents, some rating it as the most disturbing; having to care for patient and family with different education and cultural background requiring patience and good conflict management skills. Historically, it is believed that nurses have been subjected to physical, emotional and verbal abuse by patients and their families, due to their position as front-liners (Cox, 1991; Diaz and McMillan, 1991; Rowe and Sherlock, 2005). More respondents thought that patients and families make unreasonable and inappropriate demands, once again the culture factor being strongly highlighted:

- M: some of the patients are very stressful, especially some cultures whatever we do they are not satisfied the family, no matter how much you will give, they are not appreciating (Interview 7, paragraph 9, p. 5)
- LS: for example, we had one patient recently. The family were staying three in the room at night despite being told repeatedly in their language only one person to stay do not overfeed the patient they ignored every piece of advice I find it very disrespectful (Interview 2, paragraph 7, p. 5)

An interesting picture of patient and family behavior was given by E2: E2, you see they are extremely obnoxious and rude they want KFC service they want to be served immediately and I think there is a huge lack of education level it depends from which nationality and which cultural background. I don't want to dare somebody or label somebody but is really difficult (Interview 5, paragraph 8.2, p. 3).

E2 also stated that some patients who are not served promptly call the police and mentioned three instances when nurses were called to the police station, one of them because she spoke in her own language.

CS on the other hand described clients non-compliance with rules and regulations: CS does not matter what rules or regulations are brought into hospitals, definitely (patients) do not even try to abide or adhere to it. They eat all during the night they want to have as many visitors as possible even in the labor rooms everybody brings their children the people all have family and people sleeping over and visiting and eating and drinking (Interview 4, paragraph 10, p. 3-4).

Conversely, JNN tried to justify patients and their families' behavior: JNN; they (patients) are worried, they are anxious; their families become worried and anxious. So you have to learn that every family handles things differently and you have to try to put yourself in their position sometimes, you can't just say well this is the rule (Interview 3, paragraph 12, p. 5).

Therefore, although most participants seemed frustrated, they still empathized with their patients, trying to understand their situation, feelings and motives. The last theme extracted from transcripts was "Abu Dhabi, a stressful workplace".

Participants expressed concerns about the environment, cost of living and legal aspects impacting on their work. Even though these factors represent external stressors, all participants explained their indirect impact on their work stress. At least six participants were irritated with the road traffic. Congestion and traffic jam resulting in delays to and from work were described as "nerve wrecking" and "exhausting":

- LS: i spend effectively a day on the road, a working day on the road in a week, driving to and from (Interview 2, paragraph 11, p. 8)
- CS: the traffic is very heavy, the result is everybody has to start up very early so it makes it a very long day and we only reach home very late night (Interview 4, paragraph 5, p. 2)
- E1: when you live 15 min from the hospital it takes an hour to get home, I think that after a busy day is hard to stay in traffic for an hour (Interview 8, paragraph 24.1.2, p. 10)

The best description of the extent to which road traffic impacts on participants level of psychological stress was given by the last interviewee: EB the majority of your life is spent in the traffic very stressful if you are driving, you will get mad how it affects my work stress is my staff coming late for duty If there is a small accident on the road, people who have to report for seven o'clock duty they will reach by eight or eight thirty. Then the night staff has to stay late that is putting a lot of stress on them and is putting stress on me (Interview 10, paragraph 17, p. 8).

The high cost of living was mentioned by six nurse managers (JNN, CS, M, E1, IM and EB). Some worried for their ability to provide a decent life for their children being concerned with basic needs such as food, shelter and education. As rents in Abu Dhabi were soaring, EB felt that the management must find a solution:

EB: If accommodations will be ready for everyone, it will be great. I am not asking for hi-fi accommodation a decent accommodation for everyone. May be that is really going to help. Yes is a stressful environment mainly because of the traffic and the expenses, the rent, house rents (Interview 10, paragraph 24.1, p. 8).

JNN was a single mother who felt insecure and uncertain of her and her child's future in Abu Dhabi:

- JNN: If I am asked to leave the organization, I don't think that I can live in this country. And I think about it, what if my landlord wants the block back because my rent will be double, you worry about the future you know as far as your accommodation and your lifestyle (Interview 3, paragraph 15, p. 6). CS's felt alike saying:
- CS: we all made a choice on our own accord to be in Abu Dhabi but it can be very stressful. The traffic is very stressful, the pollution is becoming very bad, housing very expensive, even food is becoming expensive. Abu Dhabi on the whole has become very stressful (Interview 4, paragraph 15.2, p. 6)
- M: the cost of living is too high in Abu Dhabi is very difficult to think, you know for how long we will be living in Abu Dhabi unless they increase our salary (Interview 7, paragraph 14, p. 7)

She also cited the instability of the UAE's legal system. The lack of support from the governing bodies like the Department of Health and Medical Services (DOHMS) was strongly emphasized. While, E1 felt that DOHMS does not offer in fact any support to the private sector, other participants thought that DOHMS discriminates against private organizations imposing standards, rules and regulations that governmental hospitals do not have to abide to.

E1: I don't perceive them (DOHMS) to have any support to us whatsoever. What's stressful to me is that you have to wait so long to license our staff when you know that their staff does not go through licensing body. The other thing that's stressful is that they set one standard for private practice and they follow different standard themselves. So, it is frustrating (Interview 8, paragraph 20.2, p. 8-9).

Equally, JNN felt that DOHMS caused unnecessary stress to private hospitals by restricting the range of medication allowed to this sector. JNN: well in the private

sector there is limit on what medicines we are allowed to use which is very frustrating incredibly stressful (Interview 3, paragraph 17, p. 7).

Most participants perceived DOHMS licensing requirements as bizarre and inconsistent, delays in processing documents affecting the recruitment process (EB, CS and E1). They also experienced frustration with the ambiguity of nurses' scope of practice (E2, IM, EB and CS). One participant thought that although she was certified to perform Advanced Cardiac Life Support (ACLS), resuscitating patients was posing legal risks.

EB: Even if you are ACLS certified, you have to think twice before resuscitating a patient. For everything there should be a doctor's order (Interview 10, paragraph 19, p. 8).

Unlike in the UK or US a penal code for malpractice was unavailable in the UAE and medical professionals could be chased through criminal or civil courts. Although, insured for malpractice, participants have repositioned themselves as being in the world by practicing defensively and thinking twice before doing something that might increase their liability.

Each of the people interviewed identified environmental stressors such as the cost of living, pollution, traffic or the legal system. Most interviewees seemed concerned with affording a decent middle class lifestyle, a challenging goal given the circumstances.

Although, participants' accounts depicted several sources of stress, different coping strategies have been revealed as well, including family support (LS, EB, IM), sports (AM, CS), massage and spa (LS, CS, IM), prayers (M, EB), reading (JNN, E2), watching TV (JNN, E2, IM), pets (E2) and going out (S, E1, CS).

CONCLUSION

In conclusion, this current research study views stress from an ontological perspective, focusing on the subjectivity of reality. Although, work stress in nursing was extensively scrutinized over the years, nurse managers stress is underdeveloped within the research. The literature revealed two studies conducted in China, two in Texas, one in Canada, one in Sweden and one in the UK. The common denominator of all these studies was the argument that nurse managers role was redefined, becoming more complex and stressful than ever.

LIMITATIONS

There were several limitations to this research. Undertaking the study with a small sample of participants even from different private health care organizations probably represented the main limitation as generalizing

the findings was not feasible. Moreover, the population sample comprised of solely female nurse managers, researching on male nurse managers would have probably provided different findings. Selecting of the participants of Romanian nationality might have also created partiality. Another shortcoming was to conduct a single interview with each research participant; subsequent interviews could have probably offered deeper information.

The lack of literature on this topic represented another limitation to this study as the findings could be compared against only a few relevant international research studies.

RECOMMENDATIONS

All the research participants considered that the management had a significant role in addressing work stress. They advocated that occupational stress should be tackled not only reactively in terms of stress relief techniques but also proactively through support, training and performance improvement.

Based on their perceptions and researchers own views on stress management, the following suggestions could be made to the management of these organizations:

- A section of occupational health to be created in the hospitals to offer general welfare and protection to employees and minimize the ill effects of work stress and hazards
- Interpreters qualified in English and Arabic to be made available around the clock, so that the connection between medical providers, patients and families improves and cultural assistance could be provided
- Staff to be provided with recreational facilities where to relax after stressful duty hours
- Meals to be offered to staff working long shifts, nights and weekends
- Nurse managers to be given more opportunities to attend international conferences, courses in Arabic language, stress management, emotional intelligence and cultural competence
- An equitable pay scale to be implemented as well as an incentive scheme for nurses
- A recognition program such as employee of the month to be introduced
- Housing and transport to be provided to all staff, regardless of their family status

SUGGESTIONS

As the study was conducted from a hermeneutic phenomenological perspective it is limited in scope and

generalization. However, further studies might provide additional insight into occupational stress in these organizations. The following inquiries could be considered:

- A quantitative study can be performed on a larger population sample, avoiding biases and exploring the stress phenomenon from an objective perspective
- As communication was revealed as a significant stress factor, it would be interesting to study communication as a creator of stress in the multicultural workplace
- A study to explore the relationships between nurse managers and staff nurses and their perceptions of each other as creator of stress would be interesting
- Exploring the work stress in staff nurses in the same hospital and evaluating the findings against this study is another suggestion for research

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