

THE EXPERIENCE OF OVERSEAS NURSES CARING FOR MUSLIM PATIENTS IN KINGDOM OF SAUDI ARABIA AND UAE: A QUALITATIVE STUDY

¹Sami AlYateem and ²Nabeel Al-Yateem

¹Ministry of National Guards - Health Affairs, KSA

²Department of Nursing, College of Health Sciences, University of Sharjah, UAE

Received 2014-10-12; Revised 2014-10-20; Accepted 2014-11-01

Funding: This study was self funded by authors

Competing Interests: The authors have declared that no competing interests exist

ABSTRACT

Cultural competence in nursing care has always been emphasized and recommended as a quality indicator and a core knowledge requirement for all nurses. However, the provision of such culturally competent care can only be achieved when patients' cultural values and systems are known to the nurses and used appropriately to inform their practices. This study will help to reveal the different components of nurses' experiences while caring for patients from Islamic culture. This will inform the practice of service planners, managers and educators in designing interventions that address the needs of these nurses, hopefully making the nursing service more satisfying for both the nurses and the patients. A qualitative exploratory research design utilizing written narratives was used within this study. The study revealed three themes and five subthemes. The main themes were: (1) Right to practice Vs impact on care: A matter of balance; (2) Islamic principles: Nurses' knowledge; and (3) Broken lines of contact with social systems and patients. Most of participants have demonstrated insufficient knowledge and experience of Islamic principles which cannot aid them in providing culturally competent nursing care. It has also revealed that nurses should further recognize religion as an important part of the healing process and not as a factor that negatively impacts their role and hinders patient care.

Keywords: Cultural Competent Care, Cultural Sensitivity, Transcultural Nursing Care, Nursing, United Arab Emirates (UAE), Kingdom of Saudi Arabia (KSA)

1. INTRODUCTION

Within the healthcare domain, the concept of culturally sensitive and/or competent care was introduced in Leininger's trans-cultural care theory (Leininger, 1996). The theory set out that this concept contributed to a better quality service and to the promotion of the well-being of individuals and communities. The cultural competent care concept was further reinforced by many papers published

internationally and the recommendation of international organizations governing nursing practice in North America, Europe and Australia (AWHONN, 2004; Chenoweth *et al.*, 2006; Cooper *et al.*, 2007; Bloomer and Al-Mutair, 2013; Williamson and Harrison 2013; Mohamed *et al.*, 2014). The latter illustrated the significance of cultural sensitivity in nursing care and cited cultural sensitivity as a quality indicator in some organizations and as a requirement of nursing practice and a core knowledge area for baccalaureate-prepared

Corresponding Author: Sami AlYateem, National Guard Health Affairs, KSA

nurses (NSWH, 2003; ANCI, 2001; AWHONN, 2004; (AACN, 1998).

The literature has shown that a low cultural sensitivity in nursing care leads to dissatisfaction with that care and also leads to poor quality outcomes for patients and their families, in contrast to cultural considerate care which are capable of providing a more competent healthcare (Chenoweth *et al.*, 2006; Cooper, *et al.*, 2007, Jaber *et al.*, 2011; Mohamed *et al.*, 2014). However, in Leininger's theory of (TN, 1996), she emphasized the fact that such culturally competent care can only be achieved when the cultural values of patients are known by nurses and used appropriately to inform their practices.

Islam is one of the mainstream religions worldwide and forms the guide for everyday practice for millions of people both in the Arabic countries and in international healthcare settings (Jaber *et al.*, 2011, ABS, 2012; Bloomer and Al-Mutair, 2013). The religion underpins social and economic development in many of these countries, yet unfortunately has attracted little attention in research from the perspective of nurses and healthcare practitioners worldwide (Halligan, 2006; Ezenkwele and Roodsari 2014; Noll, 2014), there is also not enough done to achieve knowledge and awareness about Islam's values, principles and concepts and how these can affect these practitioners' practices in clinical settings (Hussein, 2000).

For overseas non-Muslim nurses working in Arabic countries, the difference between their clients' cultures and their own cultures can be huge and may result in a cultural shock (O'Neil, 2014, Bloomer and Al-Mutair, 2013) and consequently impact the quality of care provided. For these nurses, the religious practices of their Muslim clients can form a major challenge. Among reported challenges are male-female interaction, food preferences and related prohibitions, fasting and changing of meals and medication administration schedules, prayer times and ways of communication during prayer observances, end-of-life care, death concepts and the related burial process. For non-Arabic language nurses, caring for their clients might be further complicated by the language barrier.

Understanding Islamic principles and their effect on nursing care is very important within Arabic countries where the majority of the population follows this religion. Conversely, the majority of nurses and healthcare practitioners in these countries come from different cultures and backgrounds. Currently there is no identified process to assess overseas nurses' awareness of the religious and cultural components that can affect their practices, or their ability and readiness to interact

with patients from this culture (O'Neil, 2014). In fact, more attention was directed toward understanding the multicultural diversity, dynamics and communication between nurses themselves rather than understanding the patients' culture. Not enough is known about overseas nurses' understanding of Muslim patients' culture. This study will contribute to the body of knowledge about the cultural competence of nursing services in general and in relation to Islamic culture. It will also reveal the different components of the experiences of nurses while caring for patients from different cultures and more specifically from Islamic culture. Finally, the results of this study should help service planners, managers and educators to design interventions that address the needs of nurses who care for patients from different social, cultural and religious backgrounds, thus making the nursing service more satisfying for both the nurses and the patients.

2. MATERIALS AND METHODS

A qualitative, exploratory approach utilizing participants' written narratives was adopted within this research study. Expressing their views in writing allowed participants to share all the information they wanted, while anonymity was protected (Speziale and Carpenter, 2011; Polit and Beck, 2013; Bingley *et al.*, 2008). Participants were asked a series of open-ended questions about some main Islamic principles and practices and how these had affected their care for their patients. An example was "tell me about your experiences of caring for Muslim patients here in KSA/UAE".

2.1. Sample

All overseas nurses in participating hospitals were invited to take part using an advertisement placed on bulletin boards of the different nursing units. The advert explained the importance of the study and what the participants would be asked to do, how much of their time would be involved and what the duration of the study would be. The researcher's contact details were provided and interested staff members were asked to get in touch with their contact details. Information sessions were conducted in different departments for nursing managers to encourage them to facilitate participation of their staff. Additional information sessions were conducted in the clinical areas for nurses, to provide information and encourage their participation. Information sheets and consent forms were delivered to interested nurses by the hospital mail system. Nurses who were willing to participate signed the consent form and sent it back by the supplied envelope to the researcher.

Nurses were excluded from participating if they were Muslim and/or from Saudi Arabia, had less than two years' experience of taking care of adult Muslim patients, or had the experience of being a patient in the participating hospital, as this may influence their experiences as a nurse.

Thirty-one nurses signed and returned consent forms to the researcher through the mail system in the hospital. Four were excluded either because the participant's name was not written on the consent form (n = 2), or due to unplanned circumstances from the participant's side (n = 2). Finally 27 participants took part in the study.

2.2. Study Setting

The study was conducted in two large governmental, educational hospital in Saudi Arabia and UAE.

2.3. Data Analysis

The steps in the data analysis process were based on Tesch (1990) approach to qualitative data analysis. This

approach is supported by Creswell (2012) and is widely used in qualitative data analysis. The steps of this process are presented in **Fig. 1** below.

2.4. Ethical Considerations

Ethical approval for conducting the study was obtained from the relevant IRB committee. All data were safeguarded and protected from unauthorized access, being lost, or destroyed. All participants voluntarily signed a consent form for participation after receiving adequate information about the nature of the study and the nature of their participation in the study.

3. RESULTS

Three main themes emerged from the analysis of the data and these are presented in **Table 1** below. The following sections will report and discuss the themes and sub-themes.

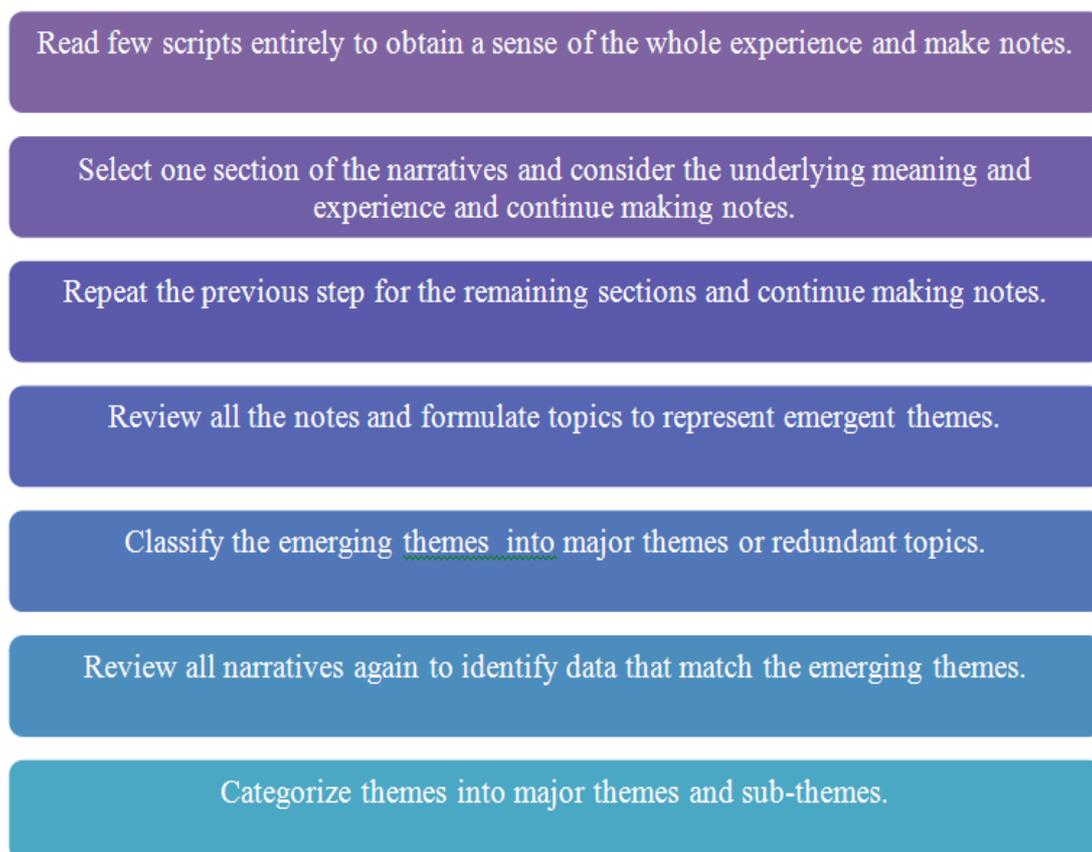


Fig. 1. Data analysis steps

Table 1. Study themes

Theme 1: Right to practice Vs impact on care: A matter of balance	Sub-theme 1: Interruption to care Vs a Chance for true caring Sub-theme 2: Big challenge Sub-theme 3: Accommodate religious practice
Theme 2: Islamic principles: nurses' knowledge	
Theme 3: Broken lines of contact with social systems and patients	Sub-theme 1: Social interaction Sub-theme 2: Individual communication

Theme 1: Right to Practice Versus Impact on Care: A Matter of Balance

This theme emerged in most participants' narratives and describes participants' perceptions of religious practices. A group of participants considered different religious practices as a barrier that may impact the caring and treatment process for the patients, examples being that prayer times may delay some medical, surgical, or nursing procedures and that fasting for long hours might lead to complications in some types of patients, according to the study participants (e.g., diabetic patients, elderly patients, pregnant women, etc.). Other participants, however, felt that it is a patient's right to practice their own religion and would be a matter of how to balance between these practices, care requirements and the treatment regimen to achieve the desirable outcomes for both the patients and the healthcare team. Three sub-themes emerged from this theme. These include the "interruption to care vs a chance for true caring", the "Big challenge" and "Accommodate religious practices".

Sub-Theme 1: Interruption to Care Vs a Chance for True Caring

Religious practices were viewed by some nurses as being an interruption to nursing care. Participants believed that it applied many limitations to care and caused delays to treatment, procedures and appointments. In fact, some participants felt that religious beliefs might restrict them from freely rendering care in the right way. One participant reported:

It delays your work; procedures are not being done on time, treatment are delay especially prayer times.' (P101, Pag1)

'It affects nursing care in a way that you cannot insist on what is right with what they believe in; like using the water for flushing tube feedings; cleaning/bathing patients.'(P101, Pag 3)

Providing assistance for some patients to perform these practices was perceived by some nurses as an extra burden and tasks that compete with other components of nursing

care, however, a minority of nurses believed that it is imperative to respect a person's religious belief and viewed this as an opportunity to interact with the patients, showing respect for their beliefs and cultures, a part of their helping role that might promote patients' healing.

'Always prove means for sick patient to practice his/her religion by providing praying sand or "TAYAMUM" within reach if they cannot go out of bed'.

'The practice of a sheik or Imam to pray for the sick are very well encourage the religious affair members are very visible on the clinical area'.(P. 104; Pag.11)

Sub-Theme 2: Big Challenges

Adherence to religious practices and commitment to these is a main characteristic of members of the Islamic religion, even during illness and hospitalization. In fact many Muslims try to strengthen their relationship with Allah (God) during illness, believing that this might contribute to their cure or healing, increasing their commitment to religious practices. This was seen as a challenge by the participants in this study. Among the main reported challenging practices were prayers, fasting and using the special holy water of Zamzam.

Obligatory prayers are performed five times a day; at dawn, noon, mid-afternoon, sunset and nightfall and thus determine the rhythm of the entire day. Muslims give a high priority to prayer and structure their daily activities according to them. The dominant role for prayers in Muslim life was observed extensively in all participants' narratives. The focus in participants' narratives was the helping role of nurses to facilitate prayers and have demonstrated some consideration and methods of communication with patients during praying. Participants reported the effort it takes to incorporate these practices within care and described that as a "big challenge". They thought prayers delayed the care process in many situations, with procedures having to be cancelled or rebooked as they occurred during praying time. One participant reported that:

'Praying form my experience is the most important thing for Moslem patient. I experienced having a procedure cancelled

because the patient needs to pray first and the escort and technician cannot wait any longer due to hectic schedule, it was rebooked on the later date; but for the patient its okay because he cannot sacrifice praying for a procedure that's the area which affects nursing care negatively'. (P101, Pag2)

Fasting was discussed extensively by participants as being important, especially in the month of Ramadan, where fasting long hours during the day is a compulsory requirement from all capable Muslims. Most nurses considered Ramadan a big challenge for them both in the professional and personal domains. In terms of professional practice, fasting was anticipated to pose risks to patients (e.g., those with diabetes, or not medically fit), interruptions in the medication administration regimen and with procedures being delayed, or cancelled. Effects on personnel included the staffing changes to accommodate Muslim staff and the unavailability of facilities that provide food for non-fasting staff.

These points were clearly stated in participant's narratives:

'The patients considered an honor to perform the fasting during Ramadan. ... we fail to convince the sick patients and they carry on with the fasting', (P104, Pag11)

'Diabetic patients insisted on fasting during Ramadan resulting to uncontrolled blood sugars'. (P101, Pag1)

'Medications needs to be adjusted; procedures are not all being done; delay due to Moslem staff availability and other things'. (P101, Pag3)

'What I don't like is that non-moslem people are blamed of drinking even water in public, not to eat freely during that period'.(P105, Pag15)

Finally, Zamzam water is a holy water for Muslims that comes from the Zamzam well in Makkah. Muslims believe that it has a healing effect and tend to use it for many purposes, especially during illness. In general, most of the participants did not object to patients using it as long as it did not harm them. However, some participants had concerns in terms of water storage and unsafe usage, such as wound irrigation. The following is a quotation from their narratives:

'My feeling is people must be allowed to use it (Zamzam) as they believed in it as long as it is not going to prevent patient's treatment'. (P105, Pag16)

'As nurses, we are to be careful to examine the container of the water because the container sometimes is tainted and the patient will end-up with a case of c-difficil or any other ailments. (P104, Pag12)

Sub-Theme 3: Accommodating Religious Practice

This sub-theme described some time management strategies used by nurses to overcome possible clashes between religious practices and nursing care. Among the most important strategies are: the effective usage of time; informing patients about procedures and care plans ahead of time; and arranging care activities to fit religious practices.

'I also give them time frame like I will come back after how many minutes in that case they will be able to adjust whatever practice or ritual they have to do'. (P101, Pag2)

'As a nurse, usually we can observe our patients of what time they are usually praying. And with that knowledge we can plan our time on when to do our nursing care , In nursing view, as a nurse we must plan our care to our patients ahead of time, as to allow praying time to our patients and no delays on our nursing care especially medications which needs to be given on time'. (P112, Pag37)

Theme 2: Islamic Principles: Nurses' Knowledge

This theme highlights the current state of knowledge of participants about Islamic principles and culture. Most of the participants acknowledged the need for sufficient religious and cultural knowledge as a crucial element in the provision of nursing care. However the majority of participants declared a knowledge deficit in this regard and said they had insufficient knowledge and no experience of Islamic principles.

It was reported that understanding the religion and culture of Saudi Arabia was essential to facilitating care in the best way and would further eliminate some of the nurses' frustrations and contribute to better (and probably safer) patient care when such religious practices are performed under the supervision of the nursing staff. If not dealt with, the reported knowledge gap might provoke

feelings of frustration, confusion and even shock. This is especially true for newly hired nurses.

'Before coming to Saudi Arabia I had no idea regarding Muslim fasting'. (P107, Pag22)

'When I just arrived here my knowledge about Islam was very limited the only knowledge about Islam was basically the head cover for women and that they have to pray 5 times'. (P104, Pag10)

'I experienced culture shock in my first six months due to the fact that I could not communicate in Arabic. Most Arabs does not know how to speak English. I had to wear an abaya which was also difficult for me in the beginning. I could no do proper nursing care for my patient, because I did not understand what they wanted'. (P110, Pag30)

Participants also reported a lack of education about the Islamic religion and the local culture; this had forced some nurses to look for information from different place; information that might be inaccurate or inadequate. The outcomes of this unstructured learning experience were having a vague understanding about Islam, or even gaining the wrong information. This was clearly evident throughout the narratives, where participants had reported this, or reported many incorrect ideas about the various religious practices and beliefs of Muslim patients.

'I've learned a lot about this religion from patients and their families, as well as with my Muslim colleagues'. (P109, Pag27)

'I don't know the Qura'an. All I know it's a book that Moslems use to pray'. (P110, Page31)

'Qura'an is the Holy book for the Muslim people it is written in Arabic it is not translated to any other language. Only those who know how to read Arabic can read the Qura'an. I think it is written by Prophet Mohammed'. (P107, Page22)

Theme 3: Broken Lines of Contact with Social Systems and Patients

Sub-Theme 1: Social Interaction

Individuals within the Arabic culture and Islamic religion are strongly connected to their extended family as well as their tribal fellows. These connections may affect the individual patient's behaviors and their support

system and family involvement in the caring process. In this theme, participants highlighted aspects related to kinship and social interactions of their patients as being important. Family was reported extensively within this theme, as were male and female relationships, gender related issues and the impacts of these on the care process were also discussed.

Having a good understanding of these social components was reported to have a significant positive effect on the provision of nursing care. This is according to the study participants' understanding of people in authority; they stated that understanding the decision-making process and the nature of interactions between both genders are essential requirements to carry out a good part of their care. However, initially during their work, it was difficult for nurses to understand all these cultural issues. Study participants identified some of these kinship and interaction patterns as being of particular concern. These included: The perceived dominant role for the male Muslim whether as a husband or a father; the role of the eldest brother as an authority person in the absence of the father; the limited or restricted role of the female even on her own treatment process in some instances; or the conservative nature of both men and women; and the limited interaction between men and women if unrelated to each other.

Participants reported all these factors had an impact on providing care and were very challenging when they initially started their careers and constantly continued to challenge their care as they became more experienced, even if to a lesser degree.

'A male is the one who makes the decisions and the female abides by it. Females are not allowed to go anywhere unless being accompanied by a male relative. Females should not also be left in a room with a male unless it is a father, brother or husband'. (P109, Pag29)

Muslim men are not allowed to see a Muslim woman except for his wife and close relatives and the Muslim women as well won't let the men see their faces to men other than their spouse and close relatives. (P102, Pag4)

During decision makings, usually it is the father who takes the responsibility and with the absence of the father, the eldest son. (P112, Pag37)

For the negative side, I'm not really sure if who will do the decision making if you have more than one family member... (P106, Pag20)

According to some participants, the special family structure could impact the caring process, in terms of male nurse assignment, delays to care due to delays in decision making and issues regarding consent signing.

'This Impact: Nurse assignment-male nurse are not allowed to care for female patient but female nurse are allowed to care for male patient'. (P111, Pag35)

'Delay of treatment because female patients cannot make any decision on the treatment to be done to her'. (P111, Pag34)

Participant nurses also reported a list of considerations that might affect their nursing care when dealing with a male or female patient, such as asking permission before touching the patient, having a female witness when a male physician examines a female patient, covering all a patient's body when transferring female patients for operation or procedure and that they should be transferred or accompanied by a female during transfer to another place or procedure.

'Always ask permission before touching them for any procedures especially female patient and explain fully to them what you are going to do'. (P101, Pag2)

'Always ask female patient's permission before letting any physician to come and examine her and don't ever leave a male doctor to examine a female patients alone; and privacy is very important in exposing patient's body part to be examine'. (P101, Pag2)

'When the patient is undergoing for a procedure (female) should always cover her face and be escorted by a female escort of if male escort, sitter must accompanied her'. (P105, Pag14)

'If the doctor needs to examine the patient (female doctor) there should be a nurse to accompanied her. If a (male doctor) examining female patient again the nurse should be present'. (P105, Pag14)

Sub-Theme 2: Communication with Individuals

Participants reported communication as among the most distressful parts of their cultural experience, especially for new nurses unable to speak Arabic. Participants described this theme in their narratives

with a lot of feeling, of fear and frustrations associated with loss of trust from the patient's side and as a leading cause for cultural shock. Respecting the patient and explaining care aspects were described by participants as a way of gaining a patient's co-operation. Not understanding or speaking the language seriously compromises those factors. Knowing this, nurses have tried to improve the communication process using interpreters, other Arabic speaking colleagues, or learning a few Arabic words or sentences.

I experienced culture shock in my first six months due to the fact that I could not communicate in Arabic... could no do proper nursing care for my patient, because I did not understand what they wanted (P110, Pag30)

If there is any misunderstanding between me and the patient, I do call the unit assistance for interpretation-since there is language barrier at times (if the patient cannot speak English) (P105, Pag14)

4. DISCUSSION

The literature has clearly supported the benefits of religion on human wellbeing, while an extensive number of studies have revealed that religion has a valuable or protective effect on a variety of health outcomes (Chatters, 2000; Curlin *et al.*, 2007; Ellison and Levin, 1998; Hall and Mdi, 2006; Jarvis and Northcott, 1987; Jones, 2004; Musick *et al.*, 2000; Schnell *et al.*, 2008). The predominant place of religion in health and illness was a constant theme in these studies and patients' views were strongly influenced by their religious convictions. This supports the findings of this study, where patients have insisted on practicing religion at all times and more so during illness, giving it in some cases more importance than some medical, surgical or nursing procedures.

The results of this study revealed that integrating cultural concepts as part of nursing care was not established in most participants' narratives. However, this could be attributed to an apparent lack of understanding by nurses of the basic concepts of the Islamic culture and the lack of preparation for nurses within this area. This is congruent with Foronda (2008) analysis of the cultural sensitivity concept, according to which nurses should first learn and understand cultural components that would consequently lead to more respect for the patient's

culture and most importantly to tailoring care to accommodate that culture. This study also revealed that nurses should further recognize religion as an important part of the healing process and not as a factor that negatively impacts their role and hinders their care. This was supported by Lawrence and Rosmus (2001) in which the authors emphasized the role of healthcare professionals in providing culturally sensitive care by adapting the treatment plan to the religious activity schedule as much as possible. The provision of cultural considerate care was further reinforced by a more recent study by Jaber *et al.* (2011) which have shown that when the nursing care and interventions are designed with close consideration to the cultural and religious beliefs of the patients, the effects of such interventions are more likely to be effective and feasible.

In this study most participants demonstrated insufficient knowledge and experience of Islamic principles. Participants' narratives showed inaccurate facts, faulty information and poor understanding. Moreover, the majority of participants had either limited or no previous exposure to Islam. This was associated with frustration from both nurses' and patients' perspectives and low self-confidence and increasing levels of stress on nurses. This was reinforced by Halligan (2006) about caring for patients from Islamic backgrounds within the critical care setting, which identified a deficit in overseas nurses' knowledge about the local culture and recommended empowering healthcare professionals with cultural knowledge that they could then integrate into their patients' care plans.

Interestingly, some nurses in this study not only lacked the local cultural knowledge to improve their nursing care, but also allowed their care provision to be affected by their own cultural system (which was often notably different). This system was used as a reference to challenge and judge their patients' decisions. This has also been noticed in the study of Aboul-Enein (2002) who proposed that although overseas nurses might have a wealth of technical clinical expertise, they may still have a deficit in providing culturally congruent care or have even tried to impose their own culture in delivering care to their local patients, which leads to confusion on both sides (patient and nurse).

At an international level, evidence has confirmed the results of this study in the presence of a widespread misunderstanding of Islamic concepts and practices especially in the context of healthcare and nursing practice (Hussein, 2000; Noll, 2014) and the lack of

congruence between patient expectations and the experience of caring received from nurses within the different healthcare settings (Cortis, 2000). Such cultural knowledge deficits can be addressed through providing nurses with an adequate knowledge base through research and educational programs (Jaber *et al.*, 2011; Chapman *et al.*, 2014) and establishing cultural competency standards that would be incorporated in institutional policy and procedures: All aimed at enabling nurses to provide culturally competent and congruent nursing care (Miller *et al.*, 2008; Ezenkwele and Roodsari 2014).

Similar to other studies in the literature (Ezenkwele and Roodsari 2014) this study revealed some unclear or misunderstood religious or cultural components, which have affected nurses' experiences and the care they provided to their patients. Among these reported misunderstood concepts are modesty, gender differences and equity. It was beyond the goals of this study to clarify for participants the correct meaning of these concepts within Islamic principles; however, the implication that these concepts might have on the provision of nursing care has been shown to cause further concerns and anxiety for both nurses and patients if not adequately understood.

Finally, it is worth emphasizing that nurses, once they have chosen to become professional healthcare providers, should adhere to this ethical and professional commitment. This commitment requires them to provide the highest possible level of care that is evidence-based and culturally competent, requiring them to approach their patients with full respect and understanding of their native culture and to integrate nursing care with the cultural and religious concepts of their patients in order to promote their healing and improve their experience.

5. CONCLUSION

Within this study, most of the participants demonstrated insufficient knowledge and experience of Islamic principles; a knowledge deficit which prevents them from providing culturally competent nursing care. The study has also demonstrated that nurses should further recognize religion as an important part of the healing process and not as a factor that negatively impacts the role of nurses and hinders their care.

6. ACKNOWLEDGMENT

Thanks to all staff nurse who took part in this study. This manuscript was prepared by both authors as group efforts at all stages. No conflict of interest to disclose.

7. ADDITIONAL INFORMATION

7.1. Funding Information

This study was self funded by authors

7.2. Author's Contributions

This manuscript was prepared by both authors as group efforts at all stages.

7.3. Ethics

No ethical issues are expected to arise after the publication of this manuscript

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