

Providing Culturally Appropriate Care to American Muslims With Cancer

Fatma Zohra Mataoui, MA, RN, and Lisa Kennedy Sheldon, PhD, APRN, BC, AOCNP®

Worldwide, Islam is the second most populous religion and, in many countries in the Middle East, South and Southeast Asia, and Africa, it is the predominant religion. The population of Muslims in the United States is projected to dramatically increase in the next few decades. Understanding the role of Islam for people who believe in and follow Islam—Muslims—will provide nurses with important perspectives that affect health behaviors, cancer screening, treatment decision-making, and end-of-life care.

Islam is the third most practiced religion in the United States and projected to become the second most practiced by 2030 (Pew Research Center, 2014). In 2014, 0.9% of the U.S. population reported to be Muslim (about 2.75 million Muslims of all ages), with a projected growth to 2.1% of the U.S. population by 2050 (Pew Research Center, 2014). The Pew Research Center (2014) estimated that 63% of current American Muslims are immigrants to the United States, presenting issues that are common for other immigrant groups acculturating to the American healthcare system and practices.

The intimate nature of cancer and cancer treatment call for oncology nurses to develop a deeper understanding of the cultural practices and health beliefs of Muslim patients. Nurses from non-Muslim backgrounds may benefit from a greater understanding about Islamic values and cultural practices that may influence health beliefs, use of health care (such as cancer screening), and the impact of family dynamics and decision-making processes (Rasool, 2015). For example, in Islam, health is viewed as one of the greatest blessings that God (Allah) has bestowed on people. Illness, suffer-

ing, and dying are a part of life and a test from God, and death is part of the journey to meet God (Loving, 2012). These beliefs also may be a source for disparities in health outcomes, including later-stage diagnoses of cancers and poorer survival outcomes. Nuclear or extended family is the core institution of Muslim society, and decisions regarding health and treatment are made collectively (Ezenkwele & Roodsari, 2013). Therefore, oncology nurses should build trust with family members in addition to the patient.

Evidence in the literature will help to guide nursing care for Muslims, with applications identified for healthcare clinicians and oncology nurses. Padela, Gunter, and Kilawi (2011) explored the needs of American Muslims by using focus groups in Michigan. Their findings identified unwelcoming behaviors in healthcare providers as a barrier to care, and specified the need for gender-concordant health care (same-gender healthcare providers caring for same-gender patients). The separation between the two genders is a norm in Muslim communities, and contact between the two genders is limited to family members (Ezenkwele & Roodsari, 2013). Skin-to-skin contact between men and women, even shaking hands, is considered inappropriate (Yosef, 2008). Muslim women, particularly married women, bear more

- Provide a welcoming environment, including appropriate hospital gowns for modesty and sufficient time and privacy to undress, identifying a room as same-gender provider only, informing the patient if a person of the other gender may be entering the room, and knocking before entering so the patient can dress appropriately, including a woman wearing a headscarf.
- Describe interventions with an understanding of how American Muslims view health and healing. Be aware that recommendations for screening and the provision of health care may influence health behaviors. For example, the value of modesty for women may result in women not obtaining mammograms or cervical cancer screening.
- Advocate for hospital and health systems to provide space or accommodations for prayer.
- Work with healthcare institutions to reach out to the American Muslim community to begin discussions about the goals for health and healing.

FIGURE 1. Insight for Oncology Nurses With Muslim Patients

burden of the house duties and raising children, which limits their time to care for themselves (Ezenkwele & Roodsari, 2013). The gender role in Muslim communities is an important factor to identify

Fatma Zohra Mataoui, MA, RN, is a doctoral candidate in the College of Nursing and Health Sciences at the University of Massachusetts–Boston and Lisa Kennedy Sheldon, PhD, APRN, BC, AOCNP®, is an associate professor in the College of Nursing and Health Sciences at the University of Massachusetts–Boston and an oncology nurse practitioner in the Cancer Center at St. Joseph Hospital in Nashua, NH. The authors take full responsibility for the content of the article. No financial relationships relevant to the content of this article have been disclosed by the authors or editorial staff. Mataoui can be reached at fatmazohra.matao001@umb.edu, with copy to editor at CJONEditor@ons.org.

Key words: Muslim; culture; cancer

Digital Object Identifier: 10.1188/16.CJON.11-12

and to consider when planning care and sharing information. Oncology nurses need to recognize the influence of men in the life of Muslim women and attempt to involve them in the health decision-making process (Kawar, 2013).

Guidelines for Care

The following are some general guidelines for providing care to Muslim patients in the cancer care setting.

Privacy and Modesty

Muslim patients keep physical contact with the opposite gender to a minimum. Therefore, patients may ask for a same-gender provider to care for them, except in case of emergency, in the absence of the preferred provider, or if the patient grants permission (Yosef, 2008). Women and men may not shake hands or may minimize direct eye contact with the opposite gender as a sign of modesty (Padela & Rodriguez del Pozo, 2011). In addition, when Muslim women are wearing hospital gowns, the oncology nurse should offer to close the curtains or keep the door closed to maintain privacy (Padela & Rodriguez del Pozo, 2011).

Dietary Needs

Muslim patients do not eat pork or pork byproducts, such as gelatin or fat (lard), and do not consume alcohol or alcohol-based products (Najeh, 2004). Therefore, Muslim patients may ask to read the ingredients of medications to avoid consuming these substances. They eat (*halal*) meat from animals slaughtered according to Islamic rites (Najeh, 2004). During the fasting month of Ramadan, patients who are ill, pregnant, or nursing (infants) are excused from the fasting (Kridli, 2011). Some patients may want to fast during

Ramadan, and this requires special care, including careful monitoring of blood sugars for diabetics and provision of predawn and post-evening meals to break the fast (Ezenkwele & Roodsari, 2013).

Spiritual Support

Prayer is one of the five pillars of Islam. Muslim patients may engage in prayer five times a day (dawn, mid-day, midafternoon, sunset, night) while facing Mecca, a holy city in Saudi Arabia (Ezenkwele & Roodsari, 2013). When a Muslim patient engages in prayer, nurses should avoid interrupting or walking in front of him or her unless for an emergency (Healthcare Chaplaincy, 2009). Before each prayer, Muslims perform the ablution (*wudu*), which is washing the exposed parts of the body such as face, hands, and feet (Najeh, 2004). If patients cannot stand up for prayer, they can sit in a chair or bed (Ezenkwele & Roodsari, 2013).

The literature has identified the influence of religious beliefs and cultural values on Muslim patients' notions of healing. Padela et al.'s (2011) groups also identified that the role of the spiritual leader (*imam*) in health promotion will provide the needed spiritual support to promote health for Muslim patients. Understanding these behaviors can influence how nurses deliver culturally sensitive care and improve the outcomes of health care.

References

Ezenkwele, U.A., & Roodsari, G.S. (2013). Cultural competencies in emergency medicine: Caring for Muslim-American patients from the Middle East. *Journal of Emergency Medicine*, 45, 168-174. doi:10.1016/j.jemermed.2012.11.077

Healthcare Chaplaincy. (2009). *Dictionary of patients' spiritual and cultural values for health care professionals*.

Retrieved from <http://www.healthcarechaplaincy.org/userimages/doc/Cultural%20Dictionary.pdf>

- Kawar, L.N. (2013). Barriers to breast cancer screening participation among Jordanian and Palestinian American women. *European Journal of Oncology*, 17, 88-94. doi:10.1016/j.ejon.2012.02.004
- Kridli, S.A. (2011). Health beliefs and practices of Muslim women during Ramadan. *American Journal of Maternal Child Nursing*, 36, 216-221. doi:10.1097/NMC.0b013e3182177177
- Lovering, S. (2012). The crescent of care: A nursing model to guide the care of Muslim American patients. *Diversity and Equality in Health and Care*, 9, 171.
- Najeh, A. (2004). Arab-American culture and health care. Retrieved from <http://www.cwru.edu/med/epidbio/mph439/Arab-Americans.htm>
- Padela, A., Gunter, K., & Kilawi, A. (2011). *Meeting the healthcare needs of American Muslims: Challenges and strategies for healthcare settings*. Retrieved from http://www.ispu.org/pdfs/620_ispu_report_aasim%20padela_final.pdf
- Padela, A.I., & Rodriguez del Pozo, P. (2011). Muslim patients and cross-gender interactions in medicine: An Islamic bioethical perspective. *Journal of Medical Ethics*, 37, 40-44.
- Pew Research Center. (2014). Demographic profiles of religious groups. Retrieved from <http://www.pewforum.org/2015/05/12/chapter-3-demographic-profiles-of-religious-groups>
- Rasool, G.H. (2015). Cultural competence in nursing Muslim patients. *Nursing Times*. Retrieved from <http://www.nursingtimes.net/roles/nurse-educators/cultural-competence-in-nursing-muslim-patients/5083725.fullarticle>
- Yosef, A.R. (2008). Health beliefs, practice, and priorities for health care of Arab Muslims in the United States: Implications for nursing care. *Journal of Transcultural Nursing*, 19, 284-291.