Home Study Program

CARING FOR THE ISLAMIC PATIENT

The article "Caring for the Islamic patient" is the basis for this *AORN Journal* independent study. The behavioral objectives and examination for this program were prepared by Jeanne F. Hately, RN, MSN, CNOR, with consultation from Eileen Ullmann, RN, MHS, CNOR, professional education specialist, Center for Perioperative Education.

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BEHAVIORAL OBJECTIVES

After reading and studying the article on caring for the Islamic patient, the nurse will be able to

(1) describe cultural differences to consider when caring for an Islamic patient,
(2) discuss the perioperative care of an Islamic patient, and
(3) describe some of the Muslim religious traditions to consider when caring for an Islamic patient.

Caring for the Islamic Patient

To provide culturally astute care, nurses should familiarize themselves with the world's religious and ethnic groups. The United States' ethnic composition is changing and will become even more diverse as we enter the next century. Religion and faith, health and illness, and life and death are all intertwined for most people. To perform an accurate assessment and provide competent care, the perioperative nurse must incorporate the patient's religious beliefs and cultural mores into the plan of care. The Islamic faith may be unfamiliar to many in the West; however, growing numbers of patients are of this persuasion.

ISLAM

Islam, or Al-Islam, is practiced along a continuum from the traditional or very strict to the more liberal religions; therefore, what one Muslim practices may not be acceptable to another. This should be remembered while rendering care to Islamic patients. Al-Islam is a monotheistic faith embracing Allah as the one God, who is creator of the universe. People who practice this religion are referred to as Islamic or Muslim. Al-Islam is a religion with more than two billion believers.[1] People practicing Al-Islam live all over the world and can be found in the United States, Europe, Africa, Asia, Malaysia, Pakistan, India, and all the Arab countries of the Middle East. The terms *Arab* and *Muslim* are often incorrectly thought to be interchangeable. Arabs comprise only 20% of the two billion Muslims and many Arabs embrace Christianity, Judaism or other faiths.[2] It is estimated that five million Muslims live in North America.[3] The ethnic background of those of the Islamic faith varies so much that nurses should take into consideration their cultural as well as spiritual differences.

The prophet Mohammed introduced Islam in the seventh century.[4] According to the Islamic faith, Mohammed was chosen by Allah to be his messenger and possessed the power to explain, interpret, and teach the Qur'an, the sacred book of Islam. This book serves as the foundation of Islamic law and is written in Arabic. As described in the Qur'an, there are five pillars in the Islamic faith:

- faith in one God (Allah) and his messenger (Shahada);
- prayer five times per day while facing Mecca, the holy city in Saudi Arabia (Salat);
- purifying or alms tax (ie, mandatory giving to the poor) (Zakat);
- Ramadan fast: dawn to sunset during the ninth month of the lunar year (Saum); and
- pilgrimage to Mecca at least once in a lifetime (Hajj).

These five pillars provide guidelines for Muslim living.

The practice of Islam is an all-encompassing way of life and therefore is more than a religion to its followers. It is entwined in every facet of their lives, from

ABSTRACT

The delivery of culturally sensitive care by perioperative nurses is an essential element of patient advocacy. To provide culturally astute care, nurses must familiarize themselves with the world's religious and ethnic groups. Islam is a worldwide religion and, like all religions, is practiced along a spectrum ranging from very conservative and traditional practices to the more liberal and contemporary ones. A person may accept some, all, or none, of the principles discussed in this manuscript. Additionally, the patient's country of origin plays an integral role in the planning of culturally competent care. *AORN J* 69 (June 1999) 1187-1196.

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birth, marriage, and family to politics, economics, and social relationships. Muslims believe that people are created equal in the Law of God, and it is very important not to hurt the feelings of another. Additionally, Muslims believe that all people are born free of sin and that there will be a day of judgment when all will be accountable for their own deeds. Life, religion, and politics are encompassed in the Islam way of life, and there is freedom of thought and expression.

Although they have designated assembly places for worship called mosques, Muslims are free to pray anywhere because the entire world is considered a place of worship. The ritual of prayer begins with the process of ablution or ritual washing. Muslims face toward the holy city of Mecca and ideally use a prayer rug (sajadah). If a prayer rug is not available, a rug, towel, sheet, or blanket may be substituted to ensure a clean place for prayer. There are five periods of prayer daily: before sunrise, at midday, in the afternoon, after sunset, and at night before sleep. Women and men follow the same daily prayer ritual; however, in the mosque, men sit in front, and women remain in the back. Figure 1 shows the Muslim Prayer Center at The Methodist Hospital, Houston.

A Muslim religious scholar is called Imam or Sheikh. An Imam does not normally visit the sick in the hospital to provide spiritual advice. The family assumes the role of providing spiritual care. Family members may pray in groups or read passages from the Qur'an to the patient. The holy day for Muslims is Friday.

Figure 1 • The Muslim Prayer Center at The Methodist Hospital, Houston.

SOCIAL ASPECTS

Kindness and consideration of others are important social responsibilities. A wide circle of relationships begins with the husband, wife, parents, children, and other relatives, then moves to neighbors, friends, orphans, widows, needy community members, fellow Muslims, fellow human beings, animals, trees, and plants. Muslims believe they should be sincere and truthful while demonstrating modesty, humility, and control of passions and desire. Parental respect is held in high regard. The Muslim faith places men at the head of the family, and it is accepted that Islam is a paternalistic society. All Muslim men and women are equal in the eyes of Islamic law, but they have different natures, capacities, and dispositions. The relationship of husband and wife is complementary, and, to preserve the family bond, mutual expectations and obligations are required.[5] Men are responsible for the protection, maintenance, and economic security of the family. Women are responsible for raising and educating children and providing a comfortable family environment.[6] Men are encouraged to help their wives, and wives are obliged to care for and be attentive to their families. The care of spouse and family is very important to the Muslim wife.

The Qur'an does not prevent women from working outside of the home; however, the first commitment of a wife is to nurture her children and marriage. The mother plays a very important role in the moral teachings of her children. Mothers and daughters have very close, intimate relationships. The father is authoritative and is the chief disciplinarian, and the mother remains a symbol of comfort and compassion throughout the child's life. This lends understanding to the popular saying of Mohammed, "Paradise is at the feet of the mother."[7]

Modesty is very important to the Muslim patient, and a woman's honor and chastity must be respected in all circumstances. The Muslim family may request an all-female staff of care providers, and a husband may ask to stay with his wife during a physical examination. Ideally, Muslim women must keep their hair, body, arms, and legs covered at all times (Q: At all times? Not just in public?), and their clothing should not reveal the shape of their bodies. Muslim women from some countries cover their faces. There are various dress modifications that are dependent on cultural background. Some Muslim women wear a black cape garment called an abaya over their clothing, and others wear loose clothing or full-length skirts or slacks and cover their hair and upper body with a

scarf (hijab). Some young Muslim women dress in Western or modern styles, and a specific faith is not recognizable from their dress.

A Muslim woman should not be left alone with a man who is not her husband or relative. Eye contact is usually avoided between unrelated men and women. Physical contact, touch, and hugs between nonfamily members of the opposite sex are usually socially unacceptable. The traditions concerning childbirth vary but are usually are considered to be in the female domain. Women may follow a traditional seclusion without a shower for 10 days postpartum. Most Muslim mothers breast feed their babies and wrap their babies to prevent cold from entering the body. If the father is in attendance at the birth, he may wish to be involved in the cleansing of the infant and offer praise to Allah in the baby's right ear. Some parents wish to have the placenta saved for burial. Circumcision is the norm in Muslim countries and is practiced in the tradition of the prophet Abraham. There is no minimum or maximum age for circumcision.

DIETARY REQUIREMENTS

Food has a central role in the lives of Muslim families, and dietary restrictions may vary between countries depending on how the members follow tradition. The diet of the Muslim patient should not contain pork, pork products, or alcohol. Most Muslims will not eat shellfish, and some believe meat must be "halal," that is, from animals slaughtered in a prescribed manner. Some patients desire a Kosher or vegetarian diet. During Ramadan, the ninth month of the Muslim year, fasting occurs from dawn to sunset for 28 days and includes abstinence from food, drink, smoking, and sexual intercourse. It is believed that fasting teaches obedience to God and is required only by adults who are physically capable and mentally competent. Elderly people, ill people, travelers, pregnant women, lactating mothers, menstruating women, women with postpartum discharge, and women who have experienced a miscarriage are exempt from fasting.[8] Children are exempt, but at the age of 12 or 13, adolescents attempt to fast in preparation for adulthood.[9]

ILLNESS AND DEATH

Muslims view physicians as authority figures and defer to their opinions and judgments. Muslims know that cancer and other serious or fatal diseases may be influenced by environmental factors, but when afflicted, they believe it is fate and the will of God. Repression of emotions may be the patient's way of coping. Men usually mask their emotions, and women frequently feel free to express sadness, pain, and apprehension. It is not unusual for Muslims with a serious or terminal illness not to be told the diagnosis by family members. This decision depends on the patient's age, role in the family, and ability to help plan his or her care. The Qur'an teaches that when one needs help from God, such as forgiveness of sin, or recovery from illness, they should ask Allah directly.

The dying person may wish to face Mecca, and a relative may whisper the call to prayer in the patient's ear.

Muslims do not wish or plan for death. It is believed that one should never give up hope because to do so would be to defy the will of Allah. The husband or eldest son is usually the spokesperson during a life-threatening or terminal illness of a family member. The dying person may wish to face Mecca, and a relative may whisper the call to prayer in the patient's ear.[10] Unrelated people should avoid skin contact with the body of the deceased, because it is believed that the body belongs to Allah. The nurse, therefore, should wear gloves at all times after the patient's death.

There are conflicting beliefs regarding organ transplantation. At one time it was believed that organ transplantation was not an acceptable practice. Most Islamic ethicists now conclude that there is nothing in Islamic law that forbids organ transplantation.[11] Strict Muslims do not want autopsies performed on family members except for medical or legal reasons, and embalming of the deceased is not permitted unless it is mandated by law.

When caring for the deceased, the nurse should close the patient's eyes; wrap the head with gauze dressing to ensure that the lower jaw is closed; flex the elbows, shoulders, knees and hips before final straightening (this is believed to ensure the body does

Verify medication schedules and intake during Ramadan because the patient may omit daytime medication doses.

not stiffen and aids in purification); and turn the deceased's head toward the right shoulder so the body can later be buried facing Mecca. Health care providers should not wash the body of the deceased or cut the hair or nails because ritual washing is performed by another Muslim.[12] In the event of a miscarriage or stillbirth, Islamic ethicists consider the fetus a person at 120 days from conception, at which time the fetus becomes "ensouled."[13] Usually, the family will want to be given the fetus or stillborn baby for burial.

The Qur'an states that life is the preparation for eternal life after death. This belief not only guarantees success in the hereafter but also makes the world full of peace and happiness by making the individual more responsible for his or her activities.[14]

Death of a loved one brings a sense of loss and helplessness to the grieving family. This is a universal phenomenon, and comforting words greatly help the surviving family members. Two beliefs (ie, Allah appoints the time of death, there is life after death) help Muslims cope with this tragedy. They also believe good deeds done in this world will be rewarded in the hereafter. The appropriate intervention is to comfort the family members through mention of the deceased's good qualities, the expected reward, and the return to Allah, according to his predestined decision.

PREOPERATIVE CONSIDERATIONS

As with any patient, the importance of communication cannot be underestimated. Language barriers may require the presence of a translator. Often, a family member, usually the head of the family, will assume this role. It is important to be courteous and develop trust, remembering the significance of the Muslim family as a whole. Involve all members in the assessment and planning of care, even though one member may be in control. Direct eye contact is considered rude and should be avoided, as should unnecessary touch between nonrelated people of the opposite sex. Public displays of affection between husband and wife are usually not acceptable behavior. Hugging or kissing a child by family members is acceptable.

The left hand is considered unclean, so the health care provider should use the right hand to administer forms, medications, and treatments. Note the patient's intake, especially during periods of fasting because the elderly and debilitated may become dehydrated. Verify medication schedules and intake during Ramadan, as daytime medication doses may be omitted, which may have severe implications for patients with diabetes or cardiac problems.

Informed consent may present a challenge if the patient is female and older than the age of 18. It is accepted practice in many Muslim-dominated countries for the husband, father, or elder brother to take responsibility and give consent for care of a female patient. Female patients older than 18 years of age will sign a consent form if asked and provided with an explanation of the legal issues in this country. Advance directives present a difficult situation because Muslims do not plan for illness or death. The nurse should discuss any concerns with the physician and family members if this is an issue, and in complicated cases, the ethics committee should be consulted. An individualized approach is necessary, taking into consideration the country of origin, Muslim beliefs, and the patient's age, diagnosis, and prognosis.

INTRAOPERATIVE CONSIDERATIONS

It is most important to preserve the patient's modesty, and the nurse should consider this a primary responsibility for all patients during anesthesia induction. The Muslim patient may wish to wear a robe, and blankets should be provided for coverage. It is acceptable to cover the hair with a surgical bonnet. If a female patient wants her face covered, as is the custom in some countries, it is usually possible until anesthesia is induced. Often, an all-female care provider team is requested for female patients. If this is not possible, a female circulating nurse should be available to offer support to the patient. In deference to Muslim beliefs, the right hand should be used to hold the anesthesia mask or the patient's hand. Many Islamic patients, especially those of Arab descent, believe that sudden shifts in temperature or cold drafts can precipitate serious illness. For this reason, as well as when caring for patients in general, it is important to keep the patient warm on entrance to the

OR suite and during the surgical procedure.

Some patients will have charms or amulets around their necks or pinned to their gowns.[16] These religious symbols should be treated with respect, and the caregiver should ask the patient or translator about the desired placement of these items during the procedure. A beard is a very important symbol to the Arab Muslim man, and permission to shave any part of it must be given because shaving to the traditional Arab is a sign of shame and dishonor.[17] If the patient has to be shaved for a procedure, the surgeon must discuss this with the patient.

Muslims have no ethical objection to blood transfusions, but they may be frightened regarding safe testing of blood products. In the event of intraoperative death, all drainage tubes should be removed, unless contraindicated by hospital policy, and the protocols previously mentioned should be followed.

POSTOPERATIVE CONSIDERATIONS

Modesty and warmth are priorities for all patients emerging from anesthesia. It is important to accurately assess pain and discomfort in the postoperative period and explain to the patient a way to rate pain on a scale of one to 10. Explaining this method preoperatively to the patient facilitates communication in the postoperative period and is particularly helpful if there is no one in the postanesthesia care unit (PACU) to translate. During teaching and discharge planning it is important that a translator is available to provide written instructions to the patient and to determine if the patient understands the instructions and how to call and obtain emergency care if necessary.

CASE STUDY

Ms A was a 19-year-old female from Saudi Arabia who presented for a right tympanoplasty and mastoidectomy. During the preoperative assessment, it was noted she had a history of chronic ear disease with no prior surgery. She had decreased hearing in the right ear without tinnitis or dizziness. Her overall health was good, and she had no allergies.

Ms A spoke limited English and was accompanied by her parents. Her father spoke English well and served as a translator. Ms A wore slacks and a loose blouse, and her hair and neck were covered by the traditional scarf (hijab). It was noted that Mr A had signed his daughter's surgical permit obtained at the surgeon's office. The preoperative nurse explained that in the United States the legal age of consent is 18, and the patient, if competent, is expected to sign his or her own permit. Mr A appeared surprised but was willing to comply and explained the situation to his daughter, who stated she understood and signed the surgical permit.

It is important that a translator is available to provide written instructions to the patient.

The perioperative staff members were aware of the request for an all-female staff to care for Ms A due to her religious beliefs. We work in a large academic institution with many patients from foreign countries, and a female interpreter was readily available. We thought having an interpreter would be more comfortable for the staff members and the patient during the preoperative preparation. Mrs A stayed at her daughter's bedside, and Mr A waited outside the curtain while his daughter changed into a hospital gown and used the restroom. Ms A removed her traditional head covering and replaced it with a surgical hat that covered her hair. The nurse covered her with warm blankets, including one draped around her shoulders to conceal her from drafts and protect her from the cool environment. Her NPO status was verified through the interpreter, and pertinent issues of postoperative diet, activities, and pain control were discussed with Ms A and her mother. Ms A was discharged to a local hotel connected to the hospital that was aware of her dietary preferences.

Ms A's surgeon visited the patient and family members to ascertain if there were any unanswered questions. He verified that all care providers except himself would be female. The circulating nurse and anesthesia care provider transported Ms A to the entrance of the OR accompanied by her parents. They kissed their daughter and were shown the waiting area and the telephone where the circulating nurse would call them with surgery progress reports.

The OR environment and sequence of events before anesthesia had been explained to Ms A preoperatively, and she transferred with assistance to the prewarmed OR bed. The blanket from around

her shoulders was removed at this time. Anesthesia induction was completed with the circulating nurse at Ms A's side holding her hand.

The surgery was completed in three hours without incidence. The surgical team members transported Ms A to the PACU and gave report to the staff members, along with the name and pager number of the interpreter. Ms A had a mastoid dressing in place over her ear, and a surgical bonnet had been placed over the dressing in the OR to maintain covering to the patient's head and hair. The perioperative nurse reiterated the importance of warmth and the protection of modesty to the PACU nurse, and a blanket was draped over Ms A's neck and shoulders after the monitoring devices were connected. It was explained that Ms A understood the postoperative protocol and would report her pain numerically on a scale of one to 10.

After a short stay in the PACU, Ms A was moved to the outpatient recovery area, where her parents were able to be at her side. She was discharged to the hotel with postoperative instructions and telephone numbers to call in case of questions or an emergency. The interpreter was available even though Mr A was able to understand the instructions and repeat them to his wife and daughter. The family had no questions and seemed pleased with the care that had been given their daughter.

Mr A thanked the nursing staff members. It was obvious that the entire family appreciated the sensitive care rendered Ms A which encompassed her cultural and religious beliefs.

CONCLUSION

Nursing care of the patient of a different culture and religion is both challenging and rewarding. The International Council of Nurses Code for Nurses contains the following statement:

"The need for nursing is universal. Inherent in nursing is respect for life, dignity and rights of man. It is unrestricted by considerations of nationality, race, creed, colour, age, sex, politics or social status."[17] With this code in mind, the perioperative nurse should be able to provide care to the patient and remain sensitive to the needs of cultural diversity. It has been said that "America is a multicultural society, yet medical care is still given primarily in a unicultural Western context."[18] It is important for nurses to increase their knowledge of transcultural care and to share this knowledge with colleagues so all professional nurses learn to provide culturally competent care. ▲

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