

ORIGINAL RESEARCH

# The art of knowing: Designing a nursing professional development program based on American nurses’ experiences of providing care to Arab Muslims

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## ABSTRACT

**Objective and methods:** The purpose of this project was to gain insight into American nurses’ experiences of providing care to Arab Muslims in order to design a nursing professional development program that supports the provision of culturally congruent care to Arab Muslims. Empirical, personal, ethical, and aesthetic ways of knowing were used to generate a comprehensive view of how American nurses describe their experiences of providing care to Arab Muslims.

**Results:** Prevailing themes included culture care knowledge, modesty, gender-specific considerations, privacy and dignity, cleanliness, worship rites, and the concept of In Shallah. Not having enough time was a significant factor influencing nurses’ intentions to provide culturally congruent care. Nurses also shared that it was less important to meet the culture care needs of acutely or critically ill patients.

**Conclusions:** The themes underscored the value of including empirical, personal, ethical, and aesthetic knowledge in the design of a nursing professional development programs in the United States and globally.

**Key Words:** Arab, Muslim, Ways of knowing, Nursing professional development

## 1. INTRODUCTION

The culture care needs of Arab Muslims are well documented in the literature.<sup>[1-4]</sup> Yet, providing care to Arab Muslim patients and families is a major challenge to American nurses. Therefore, the purpose of this project was to gain insight into and a deeper understanding of American nurses’ experiences providing care to Arab Muslim patients and families in order to inform the design of a nursing professional development program that supports the provision of culturally congruent care by American nurses for Arab Muslims.

Empirical, personal, ethical, and aesthetic ways of knowing

were used to generate a more comprehensive view of how American nurses describe their experiences of providing care to Arab Muslims and how these experiences can be integrated into nursing professional development programs. The themes derived from American nurses’ experiences are intended to enlighten healthcare organizations and interprofessional care teams of the importance of cultural competence and patient- and family-centered care<sup>[5]</sup> and guide the design of education and practice programs in the United States and globally that support the provision of safe, effective, quality care and services that are responsive to diverse consumer cultural and linguistic needs in order to achieve positive health outcomes

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for diverse populations in the service area.<sup>[6]</sup>

### 1.1 Significance

Over 1.6 billion people, approximately 23.4% of the world population, are Muslims making Islam the second largest religion worldwide.<sup>[7]</sup> The United States Census Bureau<sup>[8]</sup> estimated that at least 1.9 million Americans are of Arab descent. Adjusting for under-reporting, as some Arabs self-identify as Caucasians, the Arab American Institute<sup>[9]</sup> estimates that the number of Arab American Muslims is approximately 3.5 million. As such, providing culturally congruent care to Muslims, in general, and to Arab Muslims, in particular, is not only an issue in the United States but a global concern.

The Arab American population in the U.S. grew by more than 72% between 2000 and 2010 and is among the fastest growing populations in the world.<sup>[9,10]</sup> Although Arab Americans live in all 50 states, 94% of Arab Americans live in the following metropolitan areas: Los Angeles, Detroit, New York, Chicago, and Washington D.C.

Although there are roughly 3.5 million Arab Muslims living in the United States,<sup>[10]</sup> Americans tend to have little knowledge of the worldview of Islam and its impact on the daily lifeways of Muslims.<sup>[11]</sup> A survey conducted by the Council on American-Islamic Relations<sup>[11]</sup> confirmed that 60% of Americans are not knowledgeable about Islam.

Much of what Americans know about Arab Muslims is derived from the media and a great deal of information is skewed and inaccurate.<sup>[12]</sup> To most Americans, the terms Arab and Muslim are synonymous, but that connection is not necessarily true.<sup>[13]</sup> In fact, only 18%-20% of Muslims worldwide are Arab.<sup>[11]</sup> Consequently, 43% of Arab Americans reported experiencing discrimination because of their ethnicity or country of origin.<sup>[10]</sup>

Promoting cultural awareness among healthcare professionals is believed to improve their confidence and skills in providing holistic care for patients from different cultural backgrounds.<sup>[14]</sup> While one might assume that all people have essentially the same values, evidence suggests that there are more diversities than one can imagine among cultures due to different values, belief systems, attitudes, lifeways, and enculturation processes.<sup>[2,3]</sup> Racial, cultural, and linguistic concordance between the patient and the provider and the provision of culturally congruent care are associated with higher patient satisfaction and better health outcomes.<sup>[6,15,16]</sup> Consequently, it is critical to understand the lived experiences and insights of American nurses who have provided care to Arab Muslims in order to inform education and practice settings so that nurses can meet the culture care of Arab Muslims in meaningful, satisfying, and beneficial ways.

### 1.2 Ways of knowing

Evidence-based practice (EBP) is defined as “the integration of best research evidence with clinical expertise, and patient values”.<sup>[17]</sup> EBP emphasizes the empiric way of knowing and focuses on scientific inquiry for critically appraising and applying research data to understand and inform clinical decision-making.<sup>[18]</sup> EBP, however, is not the only way of knowing or informing nursing practice and education.

Carper<sup>[19]</sup> postulated a typology in order to classify different sources of knowledge to guide and influence professional nursing practice. The typology identifies four fundamental patterns of knowing, namely, empirical knowledge, personal knowledge, ethical knowledge, and aesthetic knowledge. Ways of Knowing, in aggregate, serve as the keystones of the art and science of nursing by underscoring the significance of experience beyond scientific inquiry as an important means for providing care that is safe, beneficial, meaningful, and satisfying, emphasizing clinical decision-making and cognitive reasoning based on experience and reflection as an essential ingredient for safe practice, and informing the broadest application of evidence in clinical practice and nursing education. Thus, the ways of knowing has therefore transformed nursing practice from relying solely on empirical knowledge to reflective practice based on experience.<sup>[18,19]</sup>

Empirical knowledge, best known as EBP, is the science of nursing-factual knowledge derived from scientific inquiry and objective experience that can be empirically verified. Personal knowledge is derived from first-hand experience, reflection, and self-awareness that, collectively, enables the nurse to interact with patients in an empathetic and authentic manner. Ethical knowledge refers to knowledge, attitudes, and practices that are derived from an ethical framework that is based on experience. Within this ethical framework, nurses integrate knowledge and experiences in order to safely respond to legal, moral, and ethical practice dilemmas with integrity, proficiency, and professionalism. Aesthetic knowledge, frequently referred to as the art of nursing, is intuitive and grounded in an understanding of the unique needs of each patient, situational awareness, and the implementation of informed practical nursing care decisions and actions.<sup>[18,19]</sup>

Ethnographic studies conducted over the past several decades have identified evidence-based best practices (empirical knowledge) for meeting the culture care needs of Arab Muslims<sup>[1-4]</sup> and have been used to guide the development of nursing curricula and professional development programs. To a lesser degree, knowledge and skills derived from personal, ethical, and aesthetic knowing have not significantly influenced the development of nursing education programs thus diluting the relevance of personal, ethical, and aesthetic

knowledge that can contribute to expert nursing practice and the provision of culturally congruent care to Arab Muslims.

### 1.3 Culturally congruent care

According to Dreher and MacNaughton,<sup>[20]</sup> cultural competence is tantamount to nursing competence. Likewise, the Institute of Medicine,<sup>[16]</sup> postulated that the key component that affects health disparities is the cultural competency of healthcare professionals. Thus, organizations must ensure cultural competence of the interprofessional healthcare team and provide patient- and family-centered care<sup>[5]</sup> and design education and practice programs that support the provision of safe, effective, quality care and services that are responsive to the diverse consumer demographics in the service area.<sup>[6]</sup>

Cultural competence is defined as an ongoing process in which the healthcare provider continuously strives to achieve the ability to effectively work within the cultural context of the client (individual, family, community). This ongoing process involves the integration of cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire.<sup>[21,22]</sup> Culturally congruent care “refers to those cognitively based assistive, supportive, facilitative, or enabling acts or decision that are mostly tailor-made to fit with an individual’s, group’s, or institution’s cultural values, beliefs, and lifeways in order to provide meaningful, beneficial, satisfying care that leads to health and well-being.”<sup>[2]</sup>

The provision of culturally congruent nursing care requires in-depth knowledge and direct experience with cultural groups.<sup>[22]</sup> Increasing one’s awareness of cultural diversity improves the possibilities for healthcare practitioners to provide culturally competent care.<sup>[4]</sup>

## 2. PROJECT DEVELOPMENT

Fifty (50) American registered professional nurses who experienced providing care to Arab Muslims were contacted for inclusion and agreed to share their experiences. Nurses were located in 14 states across the United States and had experience caring for Arab Muslim patients in the Kingdom of Saudi Arabia as well as in the USA. Email messages were sent to the nurses requesting that they write a narrative (critical incident) of a situation that stood out in their minds related to providing care to Arab Muslims.

Nurses were given a verbal explanation that included clarification of the purpose of the project and plans for the use of the information to design a nursing professional development program. The explanation included provisions for anonymity and the right to withdraw from the project. It was stressed that the information shared would be used only to design a

nursing professional development program to prepare nurses to provide culturally congruent care Arab Muslims and that the nurses’ responses were not meant to be generalized to the design of other nursing professional development programs or to other patient populations.

Narrative reports of critical incidents and responses to eight questions (see Table 1) were completed by the nurses and returned via email. A telephone or Skype conversation with each nurse followed in order to ensure the clarity, accuracy, and integrity of the nurses’ responses. The critical incident narrative and questions were reviewed and approved by content experts in transcultural nursing and nursing professional development. The themes that emerged from this project were used to design a nursing professional development program for the care of Arab Muslims (see Table 2).

## 3. ANALYSIS

The prevailing theme that emerged was the need for culture care knowledge as the foundation for the provision of nursing that meets the culture care needs of Arab Muslim patients and families. In addition, modesty, gender-specific considerations, patients’ privacy and dignity, cleanliness, and worship rites, and the concept of In Shallah were also prominent themes that provided the underpinnings of providing care that fits with the lifeways of Arab Muslims.

### 3.1 Culture care knowledge

Nurses described that “knowing” (empirical knowledge) how to care for Arab Muslim patients, knowledge gained through experience and/or through formal education, was “the single most important aspect that contributed to providing culturally congruent care in general, and specifically to Arab Muslims”. The meaning of culturally congruent care was illuminated by the nurses’ expressions of “needing to know more” and “needing to learn more about”. Nurses who attended an educational program in transcultural nursing explained that they felt more knowledgeable, comfortable, confident, and open to meeting the culture care needs of Arab Muslim patients and families, and less likely to impose their cultural values and beliefs onto the patient and family.

The majority of nurses expressed that both the nurse and the patient and family benefited from the provision of culturally congruent care. It was also explained that the nurse’s ultimate test of compassion (personal knowledge) may come from being able to provide care to patients and families who are “unlike ourselves”. The nurse also gains knowledge, insight, and meaning of care needs, and the patient is less stressed and feels safe (ethical knowledge, aesthetic knowledge).

**Table 1.** Critical Incident Narrative

<b>CRITICAL INCIDENT NARRATIVE</b>	
Title: American Nurses' Experiences Providing Care to Arab Muslims	
<u>Project Description:</u>	
The purpose of this project is to describe American nurses' experiences in providing care to Arab Muslim patients and their families in order to inform the design of a nursing professional development program that supports the provision of culturally congruent care by American nurses for Arab Muslim patients and families.	
<u>Critical Incident:</u>	
Describe a situation that stands out in your mind when you cared for an Arab Muslim patient and said "WOW, I gave care that really paid attention to this patient's culture!"	
<i>(Be specific and give as many details as you can ... basically, why does this situation stand out in your mind?)</i>	
<u>Questions:</u>	
1)	What difference does it make, (to the patient) and (to the nurse), if any, if you consider the patient's culture when planning and providing nursing care?
2)	What factors (people/place/events) most influence your intention to provide culturally congruent care to Arab Muslim patients and families?
3)	Please describe what you would consider optimal culturally congruent care for Arab Muslim patients and families. What would that care look like?
4)	Once you have made the decision to implement a culturally congruent nursing care intervention, what determines if you carry it out? Please give me an example.
5)	In your hospital/On your unit, is/was it easy or hard to tailor care to fit the cultural values of your patients/families? If it were easier to do so, would you?
6)	What do you think most affects your decision to provide culturally congruent care to Arab Muslims ... a) your attitudes to culturally congruent care? b) your attitudes toward Arab Muslims? c) the care relevant others think or expect that you provide? ... identify relevant others, d) how easy or hard it is to provide culturally congruent care?
7)	Does the cultural group of the patient/family influence your decision to provide culturally congruent care? Meaning, are you more likely to provide culturally congruent care to some groups of patients/families more than others? If so, please explain how the cultural group influences your decision.
8)	Please write or tell me anything else that you would like for me to know about this topic.

Nurses who lived and worked in more culturally diverse settings expressed that they were less likely to be influenced by the cultural group of the patient when making the decision to provide culturally congruent care. In addition, the nurses expressed frustration when caring for Arab Muslims in the USA reporting a lack of an infrastructure within U.S. health-care organizations that supports culturally congruent care and reported that culture care needs could not be recorded and communicated using the current documentation systems. Nurses who had attended an educational program in transcultural nursing reported that they experienced a higher degree of satisfaction and a greater sense of accomplishment when caring to Arab Muslim patients and families.

### 3.2 Modesty

Modesty is one of the core values in Islam. This value is expressed by both genders, though more evidently by females.<sup>[2-4, 14]</sup> Islamic teachings forbid unnecessary touching (including shaking hands) between unrelated adults of oppo-

site sexes.<sup>[1]</sup> Muslims might appear to accept to be touched by nurses of the opposite sex but that does not mean that they do so voluntarily. The patient may in fact feel badly about being touched but may have consented to it to avoid being embarrassed in front of the nurse. Nurses reported several situations that illustrated the importance of the meaning of modesty: 1) male patient wanted an all male staff to care for him; 2) ICU nurses frustrated because no male nurses were working that shift; 3) male patient agitated whenever female nurse provided care; 4) son of patient stayed with male patient and helped in patient care as much as possible when only female nurses were available; and 5) a female patient wanted an all female staff.

### 3.3 Gender

In ordinary situations, a male member leads the Arab family. It is common that Arab females tend to delegate the task of signing consents and determining treatment plans despite their legal right of making completely independent deci-

sions.<sup>[2-4,14]</sup> One nurse noted that: “Consideration given to same sex patient assignments, male nurse for male patients, female nurse for female patients. Access to the Holy Koran, Imam or other religious support, access to prayer sand, if desired, provide privacy, covering of the body, face and head of a female patient, separate female from male patients in an open ward setting such as the recovery room or the ICU, sensitivity to food menu, eliminate pork products, and if your are in a non-Muslim hospital, for example a Catholic hospital, to remove the cross from the wall.”

**Table 2.** Education Program<sup>[1-4]</sup>

<b>EDUCATION PROGRAM: CRITICAL ELEMENTS</b>	
<p><b><u>Cultural Desire</u></b></p> <ul style="list-style-type: none"> <li>• Motivation to want to engage in the process of providing culturally congruent care.</li> <li>• Influenced by attitudes, subjective norms, and perceived behavioral control.</li> <li>• Influenced by organizational culture and infrastructure, philosophy, mission, vision, values, and strategic initiatives.</li> </ul> <p><b><u>Cultural Awareness</u></b></p> <ul style="list-style-type: none"> <li>• Reflective exercises.</li> <li>• Self-evaluation, values, and beliefs.</li> <li>• Stereotypes.</li> </ul> <p><b><u>Cultural Knowledge</u></b></p> <ul style="list-style-type: none"> <li>• Caring/Culturally Congruent Care* -Patient/Family*</li> <li>• Demographics.</li> <li>• Biological variations.</li> <li>• Modesty*</li> <li>• Gender-specific considerations*</li> <li>• Privacy and Dignity*</li> <li>• Cleanliness*</li> <li>• Worship rites*</li> <li>• <i>In Shallah</i>*</li> <li>• Nursing Care = Culture Care*</li> <li>• Patient Acuity and Culture Care*</li> <li>• Culture Care references at the point-of-care.</li> <li>• Organizational policies and procedures.</li> <li>• Conflict Management.</li> <li>• Cultural never events.</li> </ul> <p>* Derived from American nurses experiences.</p>	<p><b><u>Cultural Skill</u></b></p> <ul style="list-style-type: none"> <li>• Ability to collect relevant subjective and objective culture-specific health and physical assessment data.</li> <li>• Documentation/Communication.</li> <li>• Cultural Health Assessment (CHS)<sup>+</sup>. -Language and Literacy/Interpreter Services -Communication Practices -Health Care Beliefs -Predominant Sick Care Practices -Ethnic/Race/Endemic-Specific Diseases -Health Team Relationships -Families’ Role in Care -Decision-making Patterns -Eye Contact Practices -Touch Practices -Perception of Time -Pain Reactions -Birth Rites -Death Rites -Food Practices and Intolerances -Infant Feeding Practices -Child Rearing Practices -Childhood Immunizations</li> </ul> <p><sup>+</sup> CHS is dynamic and ongoing. Not all elements are relevant at the time of initial patient contact.</p> <p><b><u>Cultural Encounters</u></b></p> <ul style="list-style-type: none"> <li>• Direct interaction with patients and families from culturally diverse backgrounds.</li> <li>• Planned clinical practica experiences.</li> </ul>

In Arab Muslim cultures, the elderly are regarded with high respect, elderly males, in particular. In the home and in the health care environment, the elderly often dictate to younger family members. Respect for the elderly is best illustrated by the excerpt below:

“I was working as the transplant coordinator, and there was a little 5-year-old boy, the beloved, oldest of two boys in his family, who needed a kidney transplant. Both of the boy’s parents were educated at American universities. The

father was a perfect tissue match for his son, but his grandfather objected to him donating a kidney. The grandfather believed that his son had a duty to take care of him in his old age, and if he donated a kidney, his health would be jeopardized and wouldn’t be available to care for his father. I spent time talking with this man, letting him know I recognized that his decision was made after great consideration and wrestling with his conscience, that he was mak-

ing the choice he believed was best for his family even as it broke his heart. The best and most culturally competent care I could give this man was to respect his struggle, honor his decision, and promise to keep looking for an organ donor. Thankfully, another donor was found and the transplant was a success.”

### 3.4 Privacy and dignity

Nurses reported that it critical to meeting the culture care needs of Arab Muslim patients and families is an understanding of the Arab Muslim’s world view of the patient’s dignity. Acknowledgement of each person’s intrinsic worth, being a unique individual, is the basic concept of dignified treatment (ethical knowledge, aesthetic knowledge).

Visiting the sick is highly encouraged in Islam and hence considerably practiced by most Muslims.<sup>[2-4,14]</sup> Relatives often travel long distances to visit patients admitted for relatively minor ailments or operations. The number of relatives, friends, and neighbors accumulating at a patient’s bedside can occasionally interfere with health care delivery, but it is essential that family visit the sick. The family and the patient would be embarrassed and “lose face” if visitors were not permitted or asked to leave. Nurses reported that 1) family members asked frequently to visit patient; 2) nurses had difficulty asking family to leave bedside; 3) son of patient stayed with patient and helped in patient care as much as possible; and 4) older sister refused to leave.

Other culturally driven aspects of care related to maintaining and preserving the dignity for Arab Muslim patients and families are privacy, modesty, and respect for the elderly. In Arab Muslim cultures, the elderly are regarded with high respect. In the home and in health care environment, the elderly often dictate to younger family members.

### 3.5 Cleanliness

Hygiene is an intrinsic value of Islamic law. Nurses reported that the most prominent aspect of cleanliness in caring for Arab Muslims was the significance of the right hand and the left hand. In Arab cultures, the left hand is the hand used for cleaning the genitals and anal area after a bowel movement and the right hand is reserved for eating, had shaking, and other hygienic activities.<sup>[2-4,14]</sup> Nursing staff are encouraged to consider the right-handed preference when administering food, medications and providing general nursing care to Arab Muslims. One nurse recalled that: “*While caring for a Kuwaiti man in the PACU the nurse (who is left handed) noticed that the son always asked her to place things on the bedside table and would not accept things handed to him in her left hand. The nurse asked me ‘Why does the son always*

*ask me to put things on the table?’”*

In Arab culture, the left hand is considered dirty and using the left hand for hygienic activities is considered offensive. The son asked the nurse to place things on the table so that he would not have to touch her left hand. He also did not explain his requests since he was concerned about offending or embarrassing the nurse.

### 3.6 Worship rites

Ritual prayer performed five times each day is one of the five fundamental pillars of Islam. For patients to be ritually clean and eligible to perform prayers, their clothes and body parts must not be soiled by any amount of urine, stool, or blood. Wudu is the ritual washing of specific part of the body (hands, mouth, nasal cavity, face, forearms, hair, feet) before prayers. Whenever Wudu is difficult or impossible to do, Tayammum (touching sand with both palms and gently sweeping it over the face and back of the hands) can be performed. Patients who are unable to perform Tayammum are exempted and shall still be able to perform prayers.<sup>[2-4,14]</sup>

Muslims who are able are expected to face Mecca when performing prayer. For many patients this is not possible and therefore the patient is exempted from facing the holy city. Muslim patients will also often ask for privacy and quiet as much as can be permitted in order to perform the prayer rituals. The importance of performing prayer and accommodating this essential Islamic ritual in meeting the culture care needs of Arab Muslim patients is illustrated by the following excerpt: “*While caring to a Saudi Arabian woman, the PACU nurse noticed that the patient kept asking the nurse what time it was, and the sister asked the nurse for a basin of water. In addition, patient and family members asked for the curtains around the bed to be closed – the nurse seemed confused by these requests.”*

Another nurse noted that: “*... when providing culturally congruent care to Arab Muslims, it is important that we change our medication schedules, especially for insulin and oral hypoglycemic agents, clinic and visiting hours, and meal times in order to accommodate fasting during Ramadan.”*

### In Shallah

Nurses stated that understanding the concept of In Shallah, Arabic for God-Willing, was paramount in meeting the culture care needs of Arab Muslims. One nurse recalled an experience when a Saudi Arabian woman recovering from surgery complained frequently of postoperative pain. The nurse would administer pain medication as prescribed based on the pain assessment. When the nurse would ask the patient if the pain was better or worse the patient would only respond “In Shallah, all will be OK.” Another nurse reported:

*“Whenever I ask him (another patient) if he is OK, all he says is In Shallah. The nurses became frustrated because they did not understand the significance of the term In Shallah and were not aware of the Islamic view that only Allah could predict the future, and that it is a sin to even think of such things.”*

The interviews highlighted that nurses believed that there was a universal concept of caring, that all patients deserved to have their care needs met. One thematic concern expressed by the participants was not having enough time to provide culturally congruent care and was explained to be the single most significant factor influencing whether or not nurses’ provided culturally congruent care.

When asked why, or if, culturally congruent care was important and, if so, what culturally congruent care to Arab Muslims patients and families “looked like”, the following responses were given:

“For me it was important to be a role model to other staff, to set the standard of professional behavior, and to support the patient in a non-threatening environment. I benefited from taking cultural competency courses and that made relations with patients and families easier.”

“If I understand its meaning and it is easy to do I will do it. If the hospital does not give me the tools I need, I may not be able to do it even if I want to.”

When asked if the cultural group of the patient and family would influence the nurse’s decision to provide culturally congruent care, it was noted that nurses living and working in multicultural environments expressed that they were less likely to be influenced by the culture of their patient than nurses working in more homogeneous environments. Nurses who had prior experience providing care for patients and families of a particular culture explained that they were more likely to and felt more comfortable and satisfied providing culturally congruent care.

### 3.7 Patient acuity

Another experiential theme of note is that many nurses’ perceptions of the need to provide culturally congruent care was related to patient acuity. Nurses explained that it was less important to meet the culture care needs of acutely or critically ill patients who may not be aware of the care being provided than it was to meet the culture care needs of the awake and alert patient in a clinic or ambulatory setting. This perception offers a point of view that has not been previously reported in the literature.

## 4. DISCUSSION

The themes derived from this project are based on the shared insights, meanings, and understandings of American nurses as they described their experiences providing care to Arab Muslim patients and families. The experiences are intended to inform healthcare organizations of the importance of cultural competence and patient- and family-centered care<sup>[5]</sup> and guide the design of education and practice programs that support the provision of safe, effective, quality care and services that are responsive to diverse consumer cultural and linguistic needs in order to achieve positive health outcomes for diverse populations.<sup>[6]</sup>

The nurses’ experiences revealed that:

- (1) culturally congruent care is based on the universal concept of caring;
- (2) knowledge of culture care needs of Arab Muslim patients was valued among participants and considered essential for the provision of culturally congruent care;
- (3) both the nurse and the patient/family benefit from the provision of culturally congruent care;
- (4) the ability to meet the culture care needs of Arab Muslim patients requires knowledge of Islam, and the concepts of cleanliness, dignity, privacy, modesty, worship rites, and gender, and In Shallah;
- (5) not having enough time was identified as the single most significant factor influencing nurses’ intention to provide culturally congruent care;
- (6) nurses believe that it is less important to meet the culture care needs of acutely/critically patients who may not be aware of the care being provided;
- (7) nurses living and working in multicultural environments were less likely to be influenced by the culture of their patient/family when making the decision of implement a culturally congruent nursing intervention;
- (8) lack of an organizational infrastructure that supports culturally congruent care hinders nurses’ abilities to meet patients’/families’ culture care needs.

The themes of this project are consistent with previously reported descriptions of the culture care needs of Arab Muslims and major influencers to the provision of culturally congruent care: 1) cleanliness, dignity, privacy, modesty, worship rites, and gender issues;<sup>[1-4]</sup> 2) lack of time to provide culturally congruent and absent/inadequate resources at the point of care;<sup>[23]</sup> and 3) need for cultural knowledge, skill, and experience.<sup>[21,22]</sup>

A significant observation by many nurses was that they believed it was less important to meet the culture care needs of acutely or critically ill patients. This information was integrated into the nursing professional development pro-

gram emphasizing the need for the provision of culturally congruent care across the continuum of care regardless of acuity and/or level of awareness and that the culture care needs of families must also be integrated into patient- and family-centered care delivery models.

## 5. SUMMARY

The experiences that emerged from this project underscored the value of including empirical, personal, ethical, and aes-

thetic knowledge in the design of a nursing professional development program aimed at preparing nurses to provide culturally congruent care to Arab Muslims. Strategies that emphasize clinical decision-making and cognitive reasoning based on the broadest application of knowledge and evidence in clinical practice and nursing education are paramount to success.

## CONFLICTS OF INTEREST DISCLOSURE

The author declares that there is no conflict of interest.

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