ALFAR, ZAINAB. Ph.D. Hospital Nurses' Experiences of Providing Care for Muslim Patients in The United States. (2021)
Directed by Dr. Susan Letvak. 93 pp.

Understanding a patient's culture is imperative to providing holistic patient care. With knowledge of cultural expectations, nurses can deliver more effective care to their patients. The purpose of the study is to describe and explore the lived experiences of non-Muslim hospital employed registered nurses providing care for Muslim patients in the United States. This study used a qualitative exploratory research design based on semi-structured interviews utilizing Husserlian phenomenology. A snowball technique was used to recruit to identify nurses' experiences of caring for Muslim patients in the United States. Ten nurses who cared for hospitalized Muslim patients were interviewed, and three major themes emerged from the participants' narratives: Nurse-patient Relationship, Nurses' Knowledge and Western Healthcare Systems, and Family Influence. Muslim patients have cultural expectations and differences that may not be anticipated by nurses, which impacts nurses' experiences when providing care. As the Muslim population continues to grow in the U.S., there is a need for increased education on culturally congruent care to assure the highest quality of nursing care.

HOSPITAL NURSES' EXPERIENCES OF PROVIDING CARE FOR MUSLIM PATIENTS IN THE UNITED STATES

by

Zainab Alfar

A Dissertation

Submitted to

the Faculty of The Graduate School at

The University of North Carolina at Greensboro

in Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

Greensboro

2021

Approved by

Dr. Susan Letvak
Committee Chair

APPROVAL PAGE

This dissertation written by Zainab Alfar has been approved by the following committee of the Faculty of The Graduate School at The University of North Carolina at Greensboro.

Committee Chair

Dr. Susan Letvak

Committee Members

Dr. Audrey Snyder

Dr. Ratchneewan Ross

Dr. Omar Alzaghari

October 4, 2021

Date of Acceptance by Committee

October 4, 2021

Date of Final Oral Examination

ACKNOWLEDGEMENTS

I would like to thank Allah, who gave me the ability to bear burdens and shed the light on this long road. I will always trust your permanent companionship which will accompany me forever. I would like to especially thank my supervisor Dr. Susan Letvak, who has believed in my abilities since day one. I cannot describe in few words my great gratitude for your continuous support, which will remain immortal in my memory. You will always be a role model for me in my career. I would like to thank the members of my research committee for their support, time and effort given to me to complete this study. Finally, I would like to thank my family, including my mother, father and siblings for their continuous support and prayers despite all the long distances!

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I: INTRODUCTION

We are living in a time of great global migration. The factors that drive migration include the search for an education or job, the economy, wars (e.g., civil wars), ethnic and religious conflicts, and poverty (Gallagher, 2018). People come from their countries of origin carrying their ideas, customs, culture, language, and history. Intellectual and cultural differences between migrants and other people may result in barriers that prevent some migrants from integrating well into societies because of misunderstandings and conflicts, and as a further result, signs of inequality, discrimination, and other consequences of diversity may appear (Pew Research Center, 2016; Wilkes & Wu, 2019). Developed countries are ahead of others in terms of accepting the diversity of races because of the economic, urban, and scientific contributions of people from various backgrounds. Consequently, those wishing to emigrate from their countries seek to settle in an environment that provides them with opportunities for various livelihoods (Anthony et al., 2018).

According to the United Nations Department of Economic and Social Affairs, the number of immigrants has increased steadily around the world over the past three decades. Indeed, the number of people migrating increased 78% from 1999 to 2019. Worldwide, the number of immigrants increased from 2.5% to 3.5% over the course of 2019 (United Nations Population Division | Department of Economic and Social Affairs, 2019). The distribution of immigrants across the world appears uneven. In 2019, more than half of the immigrants, about 272 million, were settled in 10 countries around the world ("International Migration 2020 Highlights," n.d.).

Approximately one-fifth of immigrants worldwide are in the United States. More than 44 million people living in the United States today were born in a different country (Budiman, 2020). Immigrants comprise 13.7% of the population of the United States They are distinguished

by their remarkable differences because they include different ethnic backgrounds and religions (Derose et al., 2017). Based on the previous numbers, American society is in a phase of social transition with its increasing diversity of races and ethnicities. The main factor in this transition is the impact of immigration and, thus, the increase in the number of minorities (The Integration of Immigrants into American Society, 2015).

An increasing minority in American society is the Muslim population. Based on the Pew Research Center (2018), the number of Muslims in the United States exceeded 3.45 million in 2017. This number is approximately 1.1% of the total population of America. By 2050, it is expected that the number of Muslims will double to 8 million across the United States, and this number will constitute 2.1% of the population (Pew Research Center, 2018). At the same time, the Muslim community is increasing its numbers throughout the rest of the world as well. According to a statistic from 2015, the number of Muslims in the world is close to 1.8 billion, constituting 24% of the world population ("The Changing Global Religious Landscape," 2017).

Muslims are followers of Islam which is the most widespread religion in the world and the second-largest religion after Christianity. It is an Abrahamic religion, which is marked by a monotheistic belief in God and His Prophet Muhammad. The majority of Muslims are settled in the Asian Pacific region (Lipka, 2017); however, the number of Muslims in Europe is steadily increasing, and it is expected that, in 2050, the percentage of Muslims will reach 10% (Masci, 2015). There are some factors besides immigration that have helped increase the number of Muslims worldwide. Generally, Muslim families have more children compared with families of other religions. The average number of children a Muslim mother has is 2.9, whereas for others, the average number is 2.2. In addition, Muslims are the youngest of migrants with an average age of 24 years; Muslims are, on average, seven years younger when compared with other

groups of immigrants. Therefore, the number of Muslims who are willing to give birth in host countries is naturally higher (Lipka, 2017).

The Muslim immigrant population in America comprises different races, including African, Asian, Arab, and Hispanic. Approximately 1.7 million Muslims entered the United States legally between 1991 and 2012. Moreover, about 72% of the American Muslim community are immigrants. There are 10 U.S. states characterized by many Muslims residing in them. The Muslim population by state according to recent 2020 data is listed as follows from the most to the fewest: Illinois, Virginia, New York, New Jersey, Texas, Michigan, Florida, Delaware, California, and Pennsylvania ("Muslim Population by State 2020," n.d.).

According to the World Health Organization many societies have become multiethnic as a result of decades of global immigration (World Health Organization [WHO], 2010). This increase in multiethnicity has had an impact on many aspects of society, including economic, political, and healthcare aspects (Garneau & Pepin, 2015). Worldwide, the growth of ethnic diversity among populations must be considered when providing healthcare. The phenomenon of ethnic diversity between patients and healthcare workers is increasing (WHO, 2018). One of the WHO's priorities with regard to the health of migrants is to ensure the availability of appropriate health services for them, which includes the provision of culturally appropriate healthcare (WHO, 2010). Accordingly, many policies have been established to help promote cultural health. In 2017, a policy was issued to adopt an approach based on cultural foundations for the delivery of healthcare and to integrate the importance of different cultures for the development and adaptation of health policies in global health systems (Culture Matters, 2017). With increasing cultural diversity in the United States, the need for cultural competence has become a necessity. By 2040, the demographic shift will be evident in American society, when the face of the

majority will have changed (Vespa et al., 2018). This diversity requires healthy strategies to support cultural competence. In healthcare, nurses are the first point of contact with patients and their families, and this segment is the most numerous in any health sector. In 2015, the American Nurses Association (ANA) added a new standard for practice requiring culturally congruent practice for all registered nurses (American Nurses Association [ANA], 2015a).

Culture

Culture is defined as a dynamic process that includes many aspects (Campinha-Bacote, 2002; Lai, 2000). The aspects of culture reflect general and specific pillars: language, religious beliefs, values, gender, and ethnicity. Culture may also refer to specific indications such as nationality, education, socioeconomic status, and occupation (Betancourt et al., 2002; Fisher et al., 2007). Culture is defined as a complex of actions, customs, beliefs, values, thoughts, communications, and the intersection of religion with societal rules. The individual adopts their own culture as a basis for their outlook on life and to guide them in making decisions and interacting with aspects of life. Thus, culture may influence a patient's awareness and health behavior, how they find appropriate treatment, and their perception of disease and health (Garneau & Pepin, 2015). Cultural barriers between patients and nurses have an unfortunate impact on patients. According to the results of a study examining this context, cultural barriers may cause many medical errors and reduce the quality of healthcare (Almutairi et al., 2017). According to Leininger (2002a), the primary goal with cultural care is to investigate and understand the relationship between care and culture. Therefore, nurses need to explore any patient's culture that is different from their own perspective about healthcare because this will assist them in providing better care based on a patient's cultural needs (Leininger, 2002a).

The Importance of Culturally Congruent Care for Nurses

The ANA (2015) defines culturally congruent practice in nursing as the agreement that occurs with the values and beliefs preferred by the healthcare consumer in any health system. There are many reasons for adding this new principle for nurses. Culturally congruent care assists proper care by reducing the disparities that can result from disagreement between nurses and patients, improving the quality of health care, and facilitating access for patients from different cultural backgrounds to benefit from nursing healthcare effectively. Therefore, nurses need to design culturally congruent care and direct their practice based on it (ANA,2015a). The importance of culturally congruent care is not limited to nurses in the healthcare sector only, but the importance reaches educators and researchers, alike (Marion et al., 2016). The ANA provides different competencies to support nurses in applying culturally congruent care with different educational levels for nurses, passing through graduate and advanced nursing practices. In nursing research, culturally congruent care research aims to identify the needs of racial and ethnic minority patients to reduce health disparities that may arise during healthcare delivery (ANA, 2015b). The provision of patient-centered healthcare has become a requirement in nursing care. Thus, the application of culturally congruent care contributes to a greater understanding of the patient's needs, and the nurse can provide care by understanding the patient's culture (Frazee, 2018).

Islamic Views about Healthcare

Muslims depend on their religion for their life values, including their health values (Rasool, 2015). Muslims believe that God gave them the health of their bodies and that they must maintain it until they die. Many sayings of the Prophet Mohammad provide health advice and assist Muslims in seeking treatment when they are sick (Yosef, 2008). In addition, Islam

prohibits any health risks that can attack the human body and human dignity. Because Islam offers a specific way of life for Muslims, there is a recommendation for every detail of their daily lives. Islamic religion links healthy habits to daily religious practice. For example, Muslims have to be physically clean before they practice the worship of prayer, which is held five times a day. Another aspect regarding health in Islam is diet. Islam gives a clear description of what kind of food a Muslim should eat. Muslims are allowed to eat only good (Halal) meat. Also, Islamic law forbids drinking alcohol because it can lead to many physical and mental problems, which can have negative consequences on one's daily life (Salman & Zoucha, 2010). Additionally, in Islamic culture the placenta is buried according to the commands of the Quran "from the (earth) did We Create you, and into it Shall We return you" (The Holy Quran, 20:55). A study was conducted in Saudi Arabia to determine non-Muslim nurses' knowledge about Muslim believes in the obstetric units. Non-Muslim nurses noticed that Muslim guidelines indicate that the placenta is passed to the families to send for burial (Sidumo et al., 2010).

Regardless of the diversity of the U.S. population, the health system is still not comprehensive in covering the needs of different cultures (Rasool, 2015). Additionally, there are many Islamic directives that might hinder the provision of care in hospitals as well. For example, there are many rules related to modesty that control Muslims' behaviors. A Muslim woman has to cover her body when she is outside of her home, particularly before men who are unrelated to her (Mujallad, 2016). In healthcare settings, this rule is stressful for women, particularly when the healthcare provider is male. This situation hinders a woman's freedom to express her health problems in front of male providers. The Muslim woman may feel disrespectful if she cannot maintain her modesty during a procedure, which can thus make her feel ashamed and embarrassed (Zeilani & Seymour, 2012). There are also some guidelines that Muslims follow

that are predominantly cultural rather than religious. For example, Muslim men prefer to accompany women in their family whenever they want to see a medical provider; therefore, sometimes a woman delays seeking treatment because there is no man from her family to accompany her during a doctor's visit. It can also inhibit the openness a women may have to share her concerns freely to the provider. (Al Dasoqi et al., 2013).

In light of this narrative of Islamic religious and cultural beliefs, one question remains: How can nurses properly give cultural considerations while caring Muslim patients? There has been little attention given to the emotional experiences, including frustration and conflict, of nurses who deal with cultural values significantly different from their own cultural beliefs (Lin et al., 2019).

Rationale for the Study

It is important for nurses to create a suitable environment for their patients while delivering healthcare services. Improving harmony between nurses and patients is a significant step to promoting excellent healthcare. Therefore, the idea of this proposed dissertation was to explore hospital nurses' experiences of providing care for Muslim patients in the United States. Muslims make up only 1.1% of American, thus many nurses are likely to be unfamiliar with Islamic culture. Islam is considered a way of life for Muslims, so Muslims have a culture that is significantly distinct from the majority of American nurses who are non-Muslim. As the number of Muslims living in the United States continues to rise, it is important to know what nurses' experiences of caring for Muslim patients are so potential gaps in knowledge can be addressed. Furthermore, no research studies have been identified that examine hospital nurse experiences of providing care for Muslim patients who live in the United States. This study provides beginning

knowledge that may positively affect nursing care of minority ethnic groups, like Muslims, who represent a growing part of both American society and the world.

Study Purpose and Question

The purpose of this study was to describe and explore the lived experiences of non-Muslim hospital employed registered nurses providing care for Muslim patients in the United States.

The overall question answered by the participants is the following: What are the lived experiences of hospital registered nurses providing care for Muslim patients in the United States?

Theoretical Framework

The roots of the Culture Care Theory refer back to the 1950s, when Madeline Leininger, who was a mental health nurse, worked with children from diverse cultural and ethnic backgrounds. Leininger's interest in this topic arose as a result of the United States receiving an influx of immigrants who left their home countries after World War II. Leininger observed that there were unique challenges present when dealing with these children as well as neglectful actions from healthcare professionals toward the children based on their backgrounds. (Leininger,1978,1995b). Theorists at that time implemented existing psychological ideas and applications in an attempt to uncover the needs of patients of different faiths and cultural backgrounds; however, their tools were inadequate for developing solutions that would meet patients' needs. Leininger concluded that understanding the needs of patients from cultures that are minorities in a certain area or country is a critical issue which would require further research, studies, and investigations (Leininger, 1991a).

Leininger's goal was to establish a theory that was applicable in the nursing field for nurses, but that would also be transferable to different fields for other professionals working with

diverse populations. Her creative thinking highlighted the relationship between the culture and care phenomena. The theory combines culture and care into a unique conception that explains the relationship that nurses and other professionals have when working with diverse populations. Leininger asserted that this perspective of professional relationships can have a great influence on the transformation of nursing care education and practice (Leininger, 1991b, 2002a, 2006a). Culturally based care factors are aspects believed to have an impact on human practices related to health and illness, or disabilities and death. The theory presented culture as an integrated element that describes human behavior and the emotional state of individuals. Without a comprehensive understanding of the patient's culture, the appropriate approach to care for an individual cannot be determined. Furthermore, having adequate knowledge of caring as a concept can only be achieved through examining someone's cultural context. This idea contributes to the adaptation of transcultural nursing care. It is a critical discipline and primary skill to learn in nursing (Leininger, 2006a).

This study targeted the experiences of nurses who have provided care for hospitalized Muslim patients. More specifically, the main objective of the study was to explore nurses' experiences of providing culturally congruent care for hospitalized Muslim patients. This researcher found that the Culture Care Theory was the most relevant theory to support this study's purpose. Leininger indicates that the concept of care is the essence of nursing, despite the differing definitions and divisions around this concept, each according to its culture. She provided supporting evidence and portrayed the relationship between patient culture and care as a vital concept in any health practice (Leininger,1997, 2006a). This was the main rationale behind choosing this theory to support this study. Overall, the Culture Care Theory contributes substantially to understanding the patient's culture and the need to improve the level of health

care provided to individuals who come from cultures which may be in some way different than the culture of the nurse and community. Culture Care Theory has been used widely in research, including in the experiences of nurses working with various religious and culture groups. Some studies presented nurse experiences with patients who spoke different languages, had different cultural backgrounds, and were considered a minority (Jane Cioffi, 2003; Johnstone et al., 2016; Lin et al., 2019; Listerfelt et al.,2019). Also, nurse experiences with a specific group of the population, such as psychiatric patients from different ethnic minority groups, was shown in the literature (Rosendahl et al., 2016). Moreover, there is research using the Culture Care Theory to document nurses' experiences caring for Hispanic and Mexican patients in the United States (Jones, 2008). In the literature, there are also studies that show nurses' experiences with religious minorities, such as Muslims, in their country and in western communities (Abudari et al., 2016; Halligan, 2006; Vydelingum, 2006).

The values of Muslims greatly depend on their religion, and these religious values impact their expectations of the healthcare they receive. Religion and culture are closely intertwined with Muslims, so the researcher finds that this theory sheds light on the concept of religion and the application of religious teachings through healthcare. Moreover, familiarity with the past and current way of life of the patients helps to deliver health care that takes into consideration life events in the plan of care. Often minorities have migrated to different countries, and Muslims are one of these minorities who have relocated to different countries. Another element of Leininger's theory is the environmental context and how it influences the Culture Care Theory. This context supports nurses in identifying and comprehending different circumstances such as social interaction, spiritual, political, geophysical, and ecological aspects (Leininger, 2015). Muslims as a minority influence all these factors, which may impact their health outcomes in western

communities. As a migrant category, the impact of an ecosystem on individual health appears significant. One example, though not the sole example, is the social relations of Muslims and their interactions with their community may affect their seeking of health-related services and the way they handle interactions with health professionals (Yosef, 2008). Culture Care Theory clearly draws attention to this aspect by providing sufficient explanation of the central construct, including environmental context. Another perspective that led the researcher to use this theory is that the Culture Care Theory supports the transcultural nursing care with the emic and etic concept. These constructs support the nurses in defining the differences and similarities between cultures by identifying the client/patient's internal knowledge with the external knowledge of the providers/professionals. (Leininger, 1995b, 2002b). Muslims hold beliefs about health and illness, which can impact the Muslim patients' decisions and how they respond to medical orders or the healthcare professional. Leininger asserted that conflicts can arise between the patient's internal thoughts regarding values and beliefs and the health systems and rules of the healthcare professional (Leininger, 2006b). This converges significantly in this study for the reason that Muslims have beliefs that contrast with the beliefs in the countries where they have migrated. Leininger emphasizes social structure factors, including the spiritual religion aspect and the kinship. The Muslim community values daily religious practices and social relations in the areas of kinship. This impacts the Muslim patient while receiving treatment in systems that adopt a different culture.

Leininger provides another approach which supports nurses to plan health care for cultural contexts, which include the action modes. The researcher anticipated that applying the modes would provide meaningful care to patients. Nurses are able to achieve culture congruent care for health, wellbeing or dying including decision and action; they are presented in three

modes: culture care preservation/maintenance, culture care accommodation/negotiation, or culture care repatterning/restructuring (Leininger, 2002c, 2006a, 2006b). Leininger recommends using this approach within a research study, as it can assist the researcher in achieving comprehensive outcomes related to nursing care perspectives (McFarland &Wehbe-Alamah, 2018a). Therefore, the map of these modes assisted this researcher in guiding interview questions as well as analysis of the data. Ultimately, this approach helped the researcher to collect cultural information from the nursing perspective with the intention to support and build the body of research in this area.

Definitions

Culture: shared values, beliefs, norms, and material and non-material characteristics of a particular group of people (Zimmermann, 2017).

Culturally congruent care: refers to choosing suitable therapeutic treatments which are motivated by culturally appropriate care actions and decisions (Leininger, 2006a).

Muslim patient: a patient in a hospital or medical facility who ascribes to the Islamic religion and/ or culture (Attum et al., 2018).

Summary of Chapter I

The first chapter of this study opened with a background of the significance of the study and describes the emerging Muslim population in the United States. Further, it provides some definitions that contribute to the understanding of the topic, such as definitions for culture and culturally congruent care. Also, it provides an overview of the Islamic views about healthcare. Rationale for the study, purpose of the study, and the research question are all introduced. The chapter also presents Leininger's Culture Care theory as a theoretical framework for the study.

Leininger's theory focuses on the importance of providing culturally congruent care to properly care for patients.

CHAPTER II: REVIEW OF LITERATURE

Many societies have become increasingly racially and ethnically diverse. Consequently, modifications must occur in societies to embrace this change at different levels, including the health care level. It is useful to know nursing experiences relevant to different kinds of people while providing health care in a cultural context to assure culturally congruent care. This knowledge makes it possible to change and create models that aim to serve our patients best. The aim of this literature review was to explore nurse experiences with providing health care for ethnic minority patients, including Muslims.

Method

The methodology used for this review was defined by Cooper (1998) and includes a problem formulation for the literature review, literature search, and data evaluation; data analysis; and presentation of the research. This method was used to analyze and synthesize the research focused on exploring nurse experiences providing care for racially and ethnically diverse patients. The databases used for this search were: Cumulative Index of Nursing and Allied Health Literature (CINAHL), PubMed, Scopus, PsycINFO, and Google Scholar. To expand the search, there was no limitation for the year of publication. Different combinations of keywords were used, such as “nurses,” “nursing care,” “nurse experiences,” “cultural care,” “transcultural nursing,” “diverse patients,” “minority patients,” “cultural competence,” “culturally congruent” “cultural sensitivity,” and “religious care.” Additional studies were added using the reference lists from some articles. The inclusion criteria included: (a) studies that included providing culturally congruent nursing care for ethnic minority patients; and (b) nurse experiences caring for religiously culturally diverse patients. Exclusion criteria included: (a) non-English language publications; (b) studies that did not include nurses in the sample. This review

also included evaluating the level of evidence in the studies. Ackley et al. (2008) rating scale was utilized to evaluate the assigned studies. The rating scale for the literature review ranged from level I, reflecting the highest quality of study strength, to level VII, reflecting the lowest quality. All studies included in this review were at levels V and VI.

Results

The primary search yielded 445 publications. After reading titles, the duplicated studies were removed. After this, the search identified 140 publications, of which 50 studies met the inclusion criteria for this review. Forty studies utilized a qualitative design, nine utilized a quantitative design and one utilized a mixed method design. Studies were conducted in different countries including Australia, Bahrain, Canada, England, Finland, Indonesia, Norway, Saudi Arabia, Singapore, South Korea, Spain, Sweden, Taiwan, Turkey, United Arab Emirates, and the United States. The studies publication dates ranged from 2003 to 2019. The number of participants in the qualitative studies ranged from six to 32. The largest sample size of the quantitative studies was 516 participants. Semi-structured, narrative, and in-depth interviewing, as well as focus groups, were adopted in the qualitative studies of this review. For the quantitative studies, different tools were adopted and are described below. Nurse experiences caring for diverse patients form different themes, including communication and language barriers, nurse readiness for cultural care, involving the family, cultural barriers, and strategies to overcome them, and cultural competence and cultural sensitivity of nurses.

Communication and Language Barriers

There were a number of descriptive studies addressing different aspects related to nurse experiences when dealing with patients, either from minority backgrounds or different cultures. Language barriers and ineffective communication were some of the most prominent findings in

the studies. Communication with linguistically diverse patients seems difficult according to the experience of the 23 nurses interviewed in Australia (Cioffi, 2003). Increased access to face-to-face interpreters was a helpful tool when dealing with linguistically diverse patients. However, nurses faced some difficulties when they provided care for ethnic minority people because of the lack of availability of interpreters for their languages. Also, some difficulties occurred during specific times, such as during weekend or night shifts when there may not be interpreters present. Nurses reported that telephone interpreters are inappropriate in some situations because they are three-way conversations. Additionally, patients thought their information would get back to their community through the interpreters, which led to them withholding critical health information. Availability of bilingual nurses greatly helps in facilitating communication between patients and nurses based on an understanding of the patient's culture and language at the same time. Another limitation of using interpreters was mentioned in a study that described 11 nurse experiences of using interpreters for the first meeting with Arabic-speaking mothers in Sweden. According to the participants, some interpreters had insufficient understanding of the language, which affects the translation process and, consequently, the treatment plan. Findings were consistent with other studies (Rifai et al., 2018).

In the same context, hospital emergency care nurses in Sweden found that using interpreters with limited Swedish-English proficiency is a two-sided coin (Alm-Pfrunder et al., 2018). Nurses could contact their patients, although they mentioned that using technology was an obstacle in critical situations. Nurses also preferred not to use children as interpreters in anticipation of the child's vulnerability. Using body language and voice as a part of the assessment process was a supportive tool for emergency nurses, which helped them create a

possible nurse-patient relationship. Bilingual health workers were assigned to assist nurses to communicate appropriately with linguistically diverse patients.

To clarify the role of bilingual nurses, the experiences of bilingual nurses in the provision of language-concordant care was demonstrated in a study done in the United Kingdom (Ali & Johnson, 2016). The study researchers conducted both individual interviews and focus groups with 59 nurses working in acute hospitals. This study found that nurses can communicate most effectively with patients who speak the same language as they do. Provision of language-concordant care improved the trust in a nurse-patient relationship, and it enhances the patient's satisfaction. Some nurses mentioned that patients with minority backgrounds preferred to communicate in their mother language even if their English was perfect because it made them feel good and reassured. Despite the positive side shown by the participants, some nurses reported increased workload and extra pressure with providing bilingual services. There also may only be a few bilingual nurses available for many bilingual patients, and the dialects of the language may be different.

Addressing the difficulty of communication in the operating room is presented in the literature as well. In a study by Clayton and colleagues (2016), nurses described their experiences in a multicultural operating theater from different dimensions. Participants stated difficulties when communicating with patients that directly affected their ability to perform patient care. Nurses feel uncertainty and a burden when receiving patients who speak a different language. This issue may lead to discrimination and stereotyping toward these patients in the hospital. Time is considered important in an operating theater. Nurses may not be able to initiate a relationship with the patients before procedures, which may affect the quality of care. The language barrier appears to be a theme repeated throughout many studies that explored the

perceptions of nurses in transcultural nursing practices. There were many proposals by nurses to overcome this barrier. Some preferred to work with hospital translators to ensure accuracy of translation, even if the patients preferred to use family members. Shortages of professional interpreters affect nursing care, especially if their availability is limited during the physician's meetings. (Del Pino et al., 2013; Durham & Pollard, 2010; Graham et al., 2011).

A study that interviewed nine nurses in Sweden found that the consequences of linguistic misunderstanding leads to serious outcomes with dementia patients, such as insufficient health care (Rosendahl et al., 2016). Lack of communication leads patients to become sicker, show aggressive behaviors, and also to become overmedicated. On the nursing side, lack of communication increases the burden of care. Consistent with these findings, there are many studies about nurse experiences providing care to patients belonging to sensitive groups of patients, such as those with dementia or psychiatric conditions (LicSc, 2018; Söderman, 2016). To help solve barriers to communication, nurses build relationships with family members to provide information and use their help to formulate a suitable care plan based on cultural knowledge. Nurses consider the role of families as interpreters as a key to open discussion with their patients.

Another study that focused on communication barriers with Syrian refugees was conducted with 10 Turkish nurses in a state hospital in Turkey. Nurses faced difficulties in communication in every stage of daily nursing care and could not express themselves fully to their patients. Even with interpreters, nurses would not trust the translation because of the interpreters' lack of knowledge concerning medical terminology and caring procedures (Sevinç, 2017).

AlYateem and Al-Yateem (2014) conducted a qualitative study which explored the written narratives of 27 overseas nurses who cared for patients in Saudi Arabia and the United Arab Emirates. Nurses explained that communication is mandatory to obtain satisfactory outcomes. Ineffective communication arose from lack of knowing the basic words in the Arabic language while caring for patients who speak only Arabic. This situation causes nurses great stress in trying to communicate with the patient. Fear of frustrations arise within the ineffective communication between the nurse and the patient, and even with the family. Moreover, this makes the patient lose trust in the nurse, which has a negative impact on the patient's health outcomes. The most important factor that the nurse is looking for when caring for the patient is the presence of cooperation to build a mutual relationship that serves the team, patient, and family. The loss of communication weakens the nurse-patient relationship, an important element in its construction and continuity.

A study carried out in Australia by Cioffi (2005) which interviewed 10 nurses clarified the moral concerns they faced every day with culturally diverse patients. Limited communication directly affected assessment, treatment, providing education, and giving emotional support, which all shape nursing care outcomes. In addition, using either interpreters or family members led to undermining the privacy and confidentiality of their patients in everyday care. This is consistent with another study, in which more than 70% of nurses from a sample size of 50 in a quantitative study done in Saudi Arabia found that keeping patients' information private is challenging (Sidumo et al., 2010). The daily battle nurses face is knowing their patient's feelings.

A qualitative study conducted by Halligan (2006), of 15 nurses in a critical care unit in Saudi Arabia suggests communication barriers leads to an imbalance in the emotional level of nurses, especially when providing nursing care related to cultural and religious roots. Nurses

have limited engagement in decision making, and the language difference causes a barrier to fully understand the patient's needs.

Unprepared When Encountering Patients from Different Cultures

Nurses may be unprepared to care for patients who have different cultural backgrounds. Regarding this issue, many consequences may arise, which affects culturally competent nursing care and patient outcomes. The nurse participants in studies perceived different consequences including facing conflicting beliefs and feelings of uncertainty. Participants expressed that conflicting beliefs led to massive misunderstandings, which made nurses dislike patient behaviors. This occurred when patients stood up about their beliefs, which sometimes conflicted with their health conditions. For example, in a study by Lin and colleagues (2019), a nurse reported that a "patient insisted he would not have a blood transfusion due to his religious beliefs. Even after the doctor explained his lethal situation to him, he still refused" (p. 9). In this qualitative study which interviewed 30 nurses in Taiwan, the main cause of this problem, according to one nurse's opinion, was that "[their] training in patient culture care is rather lacking." This limited the nurses' abilities to establish a nurse-patient relationship (p. 8). Another example is that some minority patients had conflicting beliefs about rehabilitation. Nurses found that those patients and their families preferred little activity for older people, which negatively affects their rehabilitation process. According to the participants, social workers and chaplains help overcome psychological barriers and boost spiritual care; failure in mitigating these barriers can change the outcomes toward the negative side.

Moreover, a qualitative study conducted in Norway involving 30 nurses reported that coping methods with dying exposed a lack of openness and some taboo topics (Debesay et al., 2014). Therefore, lack of knowledge may lead nurses to mismanage important parts of nursing

care, which may be based on the patient's cultural expression. In the same context, fear of making a mistake is a major challenge of the participants who provided intimate care to patients from various ethnic backgrounds. Nurses worried that their actions may cross cultural boundaries, which leads them to being uncertain about the care they offer to patients.

Knowledge of a patient's culture leads directly to providing comprehensive care. For example, according to Skooh et al. (2017), knowing a patient's culture helps nurses identify signs of postpartum depression in minority mothers. Additionally, a grounded theory study in Singapore which utilized interviews with 16 nurses uncovered different themes that represent challenges of nurses in multicultural communities. Nurses noted having little knowledge about a patient's culture and an inability to respond well to them and their families, resulting in their uncertainty (Wong et al., 2017). Moreover, interpreting complex and sensitive information about health care for the patient made the situation full of feelings of uncertainty. A participant stated that "fear means my inadequacy" (p. 407). Nurses expressed a lack of confidence in working with minorities, which leads to a feeling of uncertainty about their success. Nurses notice that the electronic health records are limited sources regarding sociocultural knowledge. To deal with uncertainty, nurses engaged in additional tasks such as seeking advice, conducting health dialogues with families, and collaborating with bilingual staff.

To overcome the feeling of uncertainty, nurses in one qualitative study conducted in Sweden by Johansson et al (2016), identified nurse experiences of conducting health dialogues with non-native speaking parents. Nurses stated that health dialogues assisted them in opening the discussion and gaining knowledge of the cultural context. Nurses also reported a second dimension of uncertainty regarding a nurse's knowledge and skills. Inadequate knowledge gives nurses stress and fear while caring for their patients from minority backgrounds. Nurses

described mutual learning as a bridge that matches them with the patient's culture, which directly affects the care prognosis. It leads nurses to use different tools regarding understanding the culture.

One participant in a qualitative study which included 38 health professionals in Australia expressed, "I've struggled with how to improve my minority performance in a way, acknowledging that I don't have a good handle on how I'm doing" (Watts et al., 2017, p. 86). Another uncertain situation that is common is when nurses receive new patients. Uncertainty leads to delayed health care and makes nurses feel overwhelmed or distressed. Providing equal care for minority patients is an issue described in the literature. Nurses found that patients from minority cultures get less psychological care because it is difficult to read their emotions and to understand their cultures (Watts et al., 2017). A nurse reported as follows: "it's very hard to sort of find out how depressed they may be or if they're upset plus they're visually showing signs of a flat affect or crying" (p. 86).

Nurses in a qualitative study done by Ian et al (2016) described their experiences delivering care for non-English-speaking patients in the United States. These nurses were unprepared to care for patients from different backgrounds, but they also found positive opportunities for the nurse and patient. The benefits were discussed in many aspects within the practice field, which includes an increase in knowledge about transcultural nursing care and creating mutual learning and personal development. Nurses found that providing care for minority patients triggers them to tailor different scopes of nursing practices, which assists in modifying the care based on patient preferences as much as they can. As one nurse said, "It gets you out of your 'routine' and makes you really individualize each person" (p. 259). Nurses

expressed it this way: “It has made me more patient and more conscious of my actions. It has also made me more considerate of other points of view” (p. 259).

Another study found that the presence of some obstacles, such as a language barrier and insufficient knowledge of the patient’s culture, may unintentionally lead to a lack of equality while providing care to patients from minority populations (Chen & Huang, 2018). Nurses use empathy and respect with minority patients, which pushes them to use extra effort to minimize misunderstandings that may occur in this untypical situation. Nurses indicated that caring for specific populations raised their awareness and changed their attitudes in a positive way. Moreover, caring for minority patients exposes nurses to different perceptions and coping strategies to interact with those patients and grow in cultural competence. This orientation helps nurses get rid of prejudices and correct many preconceptions regarding patient care. Addressing cultural challenges triggers nurses to emphasize cultural competencies to overcome many barriers that affect work patterns and patient care.

Involving the Family

For nurses, encounters with a patient’s family differ from one experience to another and from one situation to another in hospitals. Nurses work on the front line with families, which exposes them to some ethical situations. Nurses caring for dementia patients emphasize the important role of the family while providing care for their patients. Nurses consider family involvement an important reference in providing care and helping patients interact well in the care process. In the same context, Hoye and Severinsson (2008) explored the experiences of 16 nurses with multicultural families in Norway. Nurses showed their admiration for huge family support for patients continuously and daily. Families cover the spiritual aspect of the patient which helps in the treatment. However, in some situations, staff nurses are forced to engage

family members as interpreters. As one nurse said, “We need to be with the patient all the time and then we are forced to involve the family member as interpreters in daily caring” (p. 342). Also, nurses describe that the presence of family has an influence on nursing work and can cause complicated emotional distress. A great number of visitors negatively affects daily care and nursing procedures most of the time. A participant stated as follows: “It was very difficult, because the ward was crowded and approximately 30 people arrived” (p. 342). Influence on nursing care is considered one of the most stressful situations that may face nurses with multicultural families. Nurses emphasized that multicultural families’ reactions affect them when dealing with such situations. This is consistent with findings of other studies (Murcia & Lopez, 2016).

A qualitative study analyzing data from focus groups with 15 participants in Sweden suggested the shortage of professional interpreters is mitigated by the presence of the family members, especially in emergency situations (Listerfelt et al., 2019). Participants also reflected on the response to crises within multicultural families. Family reactions are a challenge that nurses might face during daily care of diverse patients. According to the nurses, families of minorities have different ways of responding to crises. The grieving process is different and difficult among families of diverse patients. In addition, nurses expressed that responses to crises among multicultural families can lead to drama and emotional distress even among the nursing staff. Lacking resources to support multicultural families is another stress on nurses. Some situations can cause emotional distress, such as feeling threatened and upset. Some nurses stated that the grieving process is healthy even if it is uncomfortable for nurses: “It’s just that they need to let loose their feelings” (p. 4). The nurses were unanimous that the families’ reactions may directly and negatively affect the remaining patients.

In a qualitative descriptive study including 10 nurses in Saudi Arabia, nurses noticed the positive effect when patients' spiritual needs are satisfied (Abudari et al., 2016). Some studies explored the decision-making processes within multicultural families. Some diverse patients seek to receive a family-centric decision-making process. A study which took place in Saudi Arabia and interviewed 20 nurses also mentioned that Muslim families often get too involved in the details of patient care, which interferes with the quality of care to the patients. The response from the family can lead to uncertainty of nurses. This is consistent to results in other studies, as well (Alosaimi, 2013). Another study was conducted to identify nurses' experiences of delivering care for terminally ill Muslim patients in Saudi Arabia. These nurses' opinions were that families control the decision making about end-of-life care without any participation from patients. Families want to be the first contact with physicians before patients.

Cultural Barriers and Strategies to Overcome

Many participants reported cultural barriers they may face when providing care for minority patients. Nurses in a qualitative study that included 20 nurses in the United States mentioned the great diversity of patients in one organization that affected transcultural nursing care. Nurses claimed that each minority group needs a different health model appropriate for them (Hart & Mareno, 2013). Additionally, according to the participants, gender-related issues occurred with some patients that could hinder care because female patients preferred to receive care from female providers. Also, in some cultures, men control the family and women cannot speak for themselves freely, which is reported as a significant barrier in other studies. For example, in regard to physical touching and gender, some nurses reported that male nurses can't be allocated to care for Muslim female patients, which led to delay in nursing care. Lack of resources and support at the organizational level act as a prominent barrier that affects nursing

care of minority patients. Findings were consistent in other studies (Alosaimi & Ahmad, 2016; Goodman et al., 2014; Ismail & Hatthakit, 2018).

Ethnic minority patient perceptions of illness can be different, which can be a challenge for nurses. One nurse in a mixed method study conducted in Norway stated, “They have a different perception of illness and treatment” (Alpers & Hanssen, 2014, p. 1001). Other nurses emphasized the fact that patient attitudes toward understanding illness can affect their health conditions. Patient behaviors, such as ignoring or participating in care, are based on their understanding of the illness and the etiologies of the diseases, especially if they have religious ideas about their condition. The study shows that around 80% of the participants admitted that no educational services were available that might help them care for ethnic patients. Also, only 24% of participants admitted that experienced staff were available to provide advice (Alpers & Hanssen, 2014).

One qualitative study identified the impact of religion and culture on delivered care for ethnic patients in England. Nurses noted that they should consider dietary customs when caring for patients from ethnic minority backgrounds (Vydelingum, 2006). South African nurses working in Saudi Arabia who were interviewed experienced canceled procedures because it interfered with prayer time. In addition, fasting is another challenge that was mentioned by most nurses, they need to convince their patients about the impact of fasting on their health while experiencing the worst of their illness. Findings were consistent with other studies (Van Rooyen et al., 2010).

In a study that interviewed 22 nurses in Australia, the researcher reported that the nurses think they know much about a patient until they face some issues that surprise them about their level of awareness (Johnstone et al., 2016). Caring for ethnic patients stimulates nurses to look

for educational courses that demonstrate culture nursing subjects. Nurses commented on some measures taken to overcome barriers and facilitate health care. Seeking help and adopting different resources at the organization level are available for nurses. Engaging families has a significant impact on overcoming some barriers, as the nurses described. Even nurses who spoke the same language as the patient emphasized the importance of understanding cultural issues.

Cultural Competence and Cultural Sensitivity

Several studies suggested the importance of acquiring cultural competence to provide optimal health care for ethnic minority patients and their families. Ahn (2017) demonstrated in her study a model that showed the main factors that affect nurses' cultural competence in Korea (n = 275) within the scope of providing care to minority patients. Based on the results, the hypothetical model fit the data well ($\chi 2 = 141.35$; $p \leq .001$; $\chi 2/df = 2.88$; CFI = .92; and RMSEA = .08). Some factors have direct and indirect effects on cultural competence of nurses, such as multicultural experiences, intercultural uncertainty, ethnocentric attitudes, and organizational support. Coping strategies have a direct effect on cultural competence, whereas intercultural anxiety seems insignificant in this study (Ahn, 2017). One mixed method study assessed the cultural competence through nurses' self-assessment (n = 245). The instrument developed by the authors examined topics such as intercultural knowledge, medical traditions, symptoms assessment, and the availability of education services. The study found that 44% of nurses had inadequate knowledge, and the years of experience were not significant compared with the level of knowledge ($P > .05$). In addition, around 70% of nurses faced difficulty when performing pain assessment, and 90% of them alleged their ability to assess was insufficient. Sixty percent of nurses agreed that education services were not available. The quantitative findings in this study

showed the need of adopting different strategies to improve nurses' cultural competences (Alpers & Hanssen, 2014).

Consistent with the results of the previous study, a study was conducted in Taiwan that measured the cultural competence among nurses (Lin et al., 2015). The study revealed that the participants showed low to medium-range scores when culture competence scores were measured by the nurses' cultural competence scale (NCCS). Also, nurses perceived their level of competence as "not culturally competent" with some factors that could predict their cultural competence, such as years of experience, hours of education, and frequency of dealing with minority patients and their families.

Another study showed different factors affecting cultural competence among nurses in rural areas. The cultural competence score of the participants was 3.07 on a five-point Likert scale (Suk et al., 2018). This cross-sectional descriptive study conducted included the data collected from 143 visiting nurses working in rural Korea. Perceptions of critical cultural competence (CCC) also appeared to be influenced by other aspects. The following factors, including empowerment, empathy, and cultural education, showed as statistically significant in influencing the level of cultural competence of nurses.

To compare, participants born in Asia scored lowest in the CCC scale compared with the nurses who were born in Anglo-Saxon countries. In this case, a quantitative study including data from 170 registered nurses suggested that sharing the same cultural background facilitated nursing care even if there were other differences (Almutairi et al., 2017). The study featured data from 170 registered nurses working in hospitals in Canada which were obtained using the CCC scale. The study reported a significant difference in CCC perceptions depending on two main influencers, including nurse's age, with $p = 0.05$, and country of birth, with $p= 0.029$. For more

explanation, participants who were older than 40 years reported the highest CCC score associated with cultural knowledge and awareness. It means that nurses who deal more with patients from different cultures gained experience in how to deal with them.

Another study presented different findings regarding a nurse's age (Heitzler (2017). This study measured the cultural competence of obstetric and neonatal nurses in the United States (n = 132) using the cultural competence assessment (CCA) instrument. Nurses demonstrated a moderately high level of cultural competence. However, the study reported that age was negatively correlated to the cultural competence score. The study clarified some positive correlations with some aspects, including years of experience in specific areas and the amount of educational training regarding a patient's background. The study found that attending more training supported nurses in gaining more confidence in nursing care. This is consistent with another study that investigated the cultural competence of 1432 Italian nurses using the CCA instrument (Cicolini et al., 2015). Generally, it indicated an increase to a moderate level of cultural competence after training.

One quantitative study done in Turkey with 516 nurses examined cultural sensitivity among nurses who experienced some cultural issues with their patients (Yilmaz et al. (2017). This study investigated the cultural sensitivity of 516 clinical nurses by describing and correlating data based on the intercultural sensitivity scale (ICSC). The findings of the scale were partially high among the participants. In addition, nurses faced problems, in particular with communication, health perception, and religious beliefs. Consistent with other studies, education programs as a predictive factor for increased cultural competency were significant, meaning nurses who received education in their organizations encountered fewer problems with culturally diverse patients.

Lastly, community nurses in Taiwan (n = 230) in the investigation of cultural sensitivity had a low score of 49.41 compared to the index score 65.88 (Chang et al., 2013). In addition, the study showed that the impact of lower scores in cultural sensitivity resulted in lower interaction confidence. Nurses who had less confidence when interacting with culturally diverse patients also had less cultural sensitivity. However, multicultural resources and competence training programs appeared significant as predictor variables for higher confidence levels.

Discussion

In this review several aspects that nurses face while caring for diverse patients were discussed. Studies in this review showed different themes that shape the experiences of nurses providing care for culturally diverse patients. Communication and language barriers have direct and indirect impacts on nursing care, which seems clear through the expression of the participants in several studies. The presence of negative aspects described by nurses regarding communication are an added burden on nurses, patient privacy, and accurate translation (Ali & Johnson, 2016; Alm-Pfrunder et al., 2018; Jane Cioffi, 2003). Also, families play an active role in transcultural nursing care (Høy & Severinsson, 2008). Nurses in some studies were unprepared to provide care for culturally diverse patients, either on a personal or organizational level (Markey et al., 2017; Rosendahl et al., 2016; Watts et al., 2017). Recognizing negative and positive aspects of nursing responsibility helps improve the engagement of care based on culture. Applying transcultural training can guide nurses when caring for different ethnic minorities; however, sufficient, and realistic knowledge is needed to provide quality transcultural care. Nurses cannot be blamed for not adopting cultural care. They need adequate training with education programs provided by health organizations to better care for minorities. Implicit bias

can exist when caring for minority patient populations. Health disparities can exist among levels of patient care (Clayton et al., 2016; Graham et al., 2011).

There was no availability of randomized control trials that showed culturally safe interventions for ethnic minorities. Most of the studies in the review were descriptive and limited. The studies referenced did not include empirical results that investigated the outcomes of caring for diverse patients. In addition, this review demonstrated the challenges and barriers nurses could experience in providing care for ethnic minorities. However, few studies focus on the facilitators and opportunities that may provide support to nurses while applying the cultural care in the practice field. Few studies also showed the cultural care education and implementation of appropriate models for the ethnic minority. Further research is needed to fully understand the importance and impact of the availability of different strategies that support nurses in dealing with multicultural patients and their families. This review has shown that there are few studies regarding the experiences of nurse caring for Muslim patients. Further, there were no research studies identified that were conducted in the United States that show nurses' experiences of providing care for Muslim patients who live in the U.S. As the number of Muslims living in the U.S. continues to rise, implications of the current health care practices on Muslim health, have become more prominent. The study may positively affect nursing care regarding minority ethnic groups, like Muslims, who represent a growing part of American society. It is important for nurses to create a suitable environment for their patients while delivering health care services. Therefore, the idea of this dissertation, was to explore hospital nurses' experiences of providing care for Muslim patients in the United States. Hospital nurses were chosen because of the diversity of experiences that could be highlighted during this research study.

Summary of Chapter II

This chapter has identified the relevant literature in relation to the purpose of this study. Nurse experiences caring for diverse patients form different themes, including communication and language barriers, nurse readiness for cultural care, involving the family, cultural barriers, and strategies to overcome them, and cultural competence and cultural sensitivity of nurses.

CHAPTER III: METHODOLOGY

To reach the goal of this research, the researcher adopted the qualitative method of research and with a particular focus on the phenomenological method. The research design and methodology should be selected based on the research questions and the aims of the study regardless of the personal preference of the researcher. Additionally, the literature review and prior knowledge are considered during the selection process for an appropriate method (Braun & Clarke, 2013). According to Creswell (2017), qualitative research is the best design to explore a phenomenon that needs to be explored with an understudied sample. This design is useful when the researcher needs to know more about a new concept that is not addressed in any particular manner for a specific sample or group of people. In addition, a Phenomenology approach is used to study the lived experience of individuals by exploring the features of these experiences from different dimensions (Matua & Van Der Wal, 2015). This chapter will include the research design, the study population, the procedure for data collection, and the analysis approach for the research question.

Purpose

The purpose of this study was to describe and explore the lived experiences of non-Muslim hospital registered nurses providing care for Muslim patients in the United States.

Research Design

Qualitative research methods are based on words (i.e., nonnumerical narratives) and are associated with the interpretivist philosophy, which emphasizes the way in which the world is socially constructed and understood (Braun & Clarke, 2013). It is considered an appropriate inductive approach to study specific phenomena that do not exist clearly in literature (Blaikie, 2019). The process of qualitative research includes developing questions and seeking to answer

the question through interaction with people to explore the phenomena related to their lives. Qualitative research utilizes different approaches, such as grounded theory, ethnography, narrative research, and phenomenology research. For the purpose of this study, the phenomenology approach was used to describe the lived experiences of study participants (Braun & Clarke, 2013).

The German philosopher Edmund Husserl presented phenomenology as a new line of philosophy for the first time in 1913. The philosopher defines phenomenology as a medium of expression that may be used to understand people and to describe their experiences by referring to their own senses (Husserl, 1967). Therefore, he believed that the understanding of experiences stems from a special understanding of meanings and perceptions according to people's conscious awareness of those experiences (Käufer & Chemero, 2015). The impetus for the development of this philosophical line is that Husserl believed that the positivist paradigm may result in generalizations not appropriate to the research context of the study for a particular experiment or phenomenon (Wright-St Clair, 2015). Käufer and Chemero (2015), add that the phenomenology approach seeks to find an understanding of the value of the experiences. Therefore, the experiences can be informed by emotions, such as sadness and happiness or by a phenomenon of culture and work situations. The phenomenology approach seeks to understand the relationship of experience with the phenomenon. Phenomenological philosophers believe that no phenomenon can be understood except through the experiences that create that phenomenon and through understanding how the individual influenced the meaning of the phenomenon and their interaction with it. Therefore, the main goal of research that studies phenomena is to describe the experiences as they are, and to convey them using the perceptions of the individuals involved in

the existence of those experiences (Polit & Beck, 2014). Obviously, this approach was appropriate to the tenor and purpose of this study.

Husserl and Heidegger linked phenomenology to other philosophical roots, such as epistemology and ontology. There are two aspects of phenomenology that differ according to their research, the descriptive approach, and the interpretative approach (Matua & Van Der wal, 2015). The general belief about Heidegger's philosophy is that people rely on hermeneutics and interpretations to find meaning in their lives. The difference between Husserl and Heidegger's philosophy is clear because they take a different approach in the study of a phenomenon or an experiment. Husserl relies on descriptions in his philosophy, so it is considered a completely descriptive approach that gives less attention to context. While Heidegger relies on interpretation in his philosophy, phenomenology assigns great importance to context (Von Herrmann, 2013). Heidegger criticized Husserl in saying that the researcher could dissociate from the research in a neutral way, so the meaning will be unaffected. Additionally, Heidegger believed that an individual's background directly impacts their understanding and interaction with the outside world. He refused to separate the individual from the world considering that separation is not possible. Additionally, he says that human beings exist permanently in a comprehensive global framework and their assembly is an axiom (Horrigan-Kelly et al., 2016). Therefore, when providing care to an individual, their lives outside the boundaries of healthcare should be considered. Heidegger believed that time and space are interconnected and inseparable, and, therefore, this abstract view should be projected into nursing research (Horrigan-Kelly et al., 2016). The descriptive phenomenology of Husserl was utilized in this study because it is appropriate for the purpose of this study, which sought to describe and explore acute care or hospital nurses' experiences with providing cultural health care to Muslim patients in the United

States. Moreover, this researcher preferred to use the descriptive approach to suspend previous knowledge that may contaminate the findings of the study, which impacts the participants' experiences. According to Husserl, the researcher will endeavor at every point to remain open to the experiences of the participants. Additionally, the researcher can explore the essence of the stories by asking some open-ended questions to urge the participants to share the deep meaning of their experiences with the researcher (Husserl, 1967).

Husserlian Phenomenology

As stated above, the philosopher, Husserl, was the first to establish the science of descriptive phenomenology in the year of 1920. The founding of this philosophy was because of his great interest in portrayal, which focused on human experiences (Husserl, 1967). The description of the living human experience is through several channels that the participants use to broadcast their experience, including speech, sight, hearing, remembering, and auditory and silent language (Polit & Beck, 2014). Husserl warned researchers not to attach their previous knowledge of a phenomenon while collecting data in regard to the participants' perceptions of the experience. Husserl believed that there is only one way to protect the data, by withholding the researcher's prior knowledge and attitudes, which is called bracketing (Tufford, & Newman, 2012). Bracketing is used to highlight the key phrases and descriptions that demonstrate the phenomena to be studied. Then, the researchers begin to interpret the phrases on the basis that they are informed readers. Therefore, the information obtained is to understand any experience in an abstract and subjective manner through the participants (Husserl,1960; Tassone et al., 2017). Husserlian phenomenology leads researchers to explore the characteristics of specific phenomena by using textual description to form the human experience (Tassone et al., 2017). The description is the appropriate tool for knowing the experience because understanding the

phenomena is not restricted to exploring the definition or the impact of the phenomena. Descriptions provide a deep and rich understanding of all aspects of the experience, which forms an invariant structure when analyzing the results of the participants (Kim et al., 2017). According to Husserl, researchers need to maintain the transcripts verbatim to create meaning and ideas and to experience the themes (Husserl, 1960).

Phenomenological methods were adopted by researchers to build nursing research in the 1960s (vanManen, 1990). Phenomenology is used to study many aspects of an individual's experiences, and this approach is considered one of the best ways to understand the real experiences of individuals (Lemon & Taylor, 1997). In this context, according to vanManen (1990), "phenomenology aims at gaining a deeper understanding of the nature or meaning of our everyday experiences" (p.9). Other authors support the previous idea that the main goal of phenomenological study is to explore the individual experience in abundance, which helps the researcher expand their knowledge when studying specific phenomena (Morse & Field, 1996).

Use of phenomenology to explore hospital nurses' lived experiences in providing care to Muslim patients can help provide good information for understanding transcultural nursing care, which nurses face on an ongoing basis, particularly in western societies. Based on the literature, studies presenting nurse experiences in providing culture care to ethnic minorities have been conducted globally (Debesay et al., 2014; Johnstone et al., 2016; Listerfelt et al., 2019). Other studies presented nurse experiences in dealing with families of minority patients in particular (Høye & Severinsson, 2008; Johansson et al., 2016). Some studies presented nurses' experiences with a specific minority, such as Muslims or immigrants from a specific country (Halligan, 2006; Sidumo et al., 2010; Alosaimi, 2013).

Sample Description and Setting of the Study

For the present study, a purposeful snowball sample of participants included all non-Muslim registered nurses working in hospital settings who have cared for Muslim patients in the U.S. Exclusion criteria are Muslim nurses. There was no computational method for the sample size in qualitative studies because the saturation in understanding a phenomenon causes the researchers to continue or stop collecting data. The researcher must complete data collection until they reach a sufficient number of responses to answer the research question (Vasileiou et al., 2018). The researcher of this study did not limit the number of participants and expanded the study instead of limiting it to obtain a comprehensive understanding of the experiences of nurses in providing care for Muslim patients in the United States. The focus of this study was on the quality of the information obtained from the interviews and not on the number of participants. The researcher utilized social networking, such as Facebook and Instagram, and snowball sampling to recruit potential participants. The researcher is a Muslim nurse and PhD student at the University of North Carolina at Greensboro (UNCG) School of Nursing. The researcher attends classes with other nurses. The researcher used word-of-mouth recruiting and snowballing to recruit participants. The contact information for the researcher was provided in the announcement for the study (see Appendix A). The research participants were informed about the research topic, the objective of the study, and the information sheet (consent form) and how to set up the time for their interview. Participation in the study qualified the participants to win a gift card after completing the interview session.

Data Collection Procedure

Phenomenological research seeks to expose the phenomena of interest by eliciting the experiences of specific groups of people who have already lived the experiences at another time

(Husserl, 1960). To understand the experiences of nurses, as is the aim of the current study, Singer and Couper (2017) suggested that the importance of the interview is not, in fact, to answer the stated questions but in understanding the lived experiences to be highlighted. Open-ended interviews help the researcher obtain information and, at the same time, the participant can answer without interference (Singer & Couper, 2017). There are different formats for the interview as an instrument for qualitative research, which includes the unstructured, semi-structured, and structured interview. Structured interviews are common with interviews that are based on quantitative research. However, semi-structured interviews are based on a list of questions, which may include other questions that arise during the interview. Semi-structured interviews are the most common interview style used in qualitative research. Unstructured interviewing is based on themes or topics adopted by the researcher for discussion with participants (Braun & Clarke, 2013). Therefore, as stated previously, this study used semi-structured interviews because it was appropriate for exploring experiences and situations in the healthcare environment (DiCicco-Bloom & Crabtree, 2006).

Semi-Structured Interview

The semi-structured interview is considered the dominant approach in qualitative research, which is characterized by a nonrigid style. The researcher can be flexible and precise when choosing the words of the questions and the order of the interview questions (Braun & Clarke, 213). The research question can serve as the initial question for the interview, which opens the door for the remaining questions and to discover the experiences of the participants. The researchers may want to change the direction of some interview questions because the participants are not engaging and interacting well with the proposed research issues. According to Polit and Beck (2014), the researcher needs to clarify the question for the participants to

ensure they are on the same page by adopting reflection techniques and asking them to provide examples.

The development of the interview guide was initially based on the brainstorming process (Smith et al., 2009). The researcher kept some questions, and the other interview questions were excluded. Then, the researcher identified some aspects that are related to the area of interest from reviewing the literature. There were some issues that arose while developing the interview guide, such as sensitive questions or some questions that explore the personal reactions against a specific situation. In this case, the researcher modified the questions based on the participants' characteristics (Braun & Clarke, 2013). Also, the researcher used the Theory of Culture Care to develop some questions (see Appendix B). It is recommended that researchers test the interview guide before conducting the study. Reviewing the questions after a few interviews is important because it assists the researcher in modifying some questions in terms of wording or clarity (Charmaz & Belgrave, 2012). Moreover, analyzing the pilot study supports the researcher in revising the interview guide based on the direct interaction with participants from the same population (Braun & Clarke, 2013). The researcher conducted a pilot study with three registered nurses, who cared for Muslim patients in an intensive care unit, delivery room, or hospice and participated in a 1:1 interview. Four major themes emerged from data analysis which include Islamic principles: nurse's knowledge and education, nurses' challenges, nurse- patient relationship, and family matter. The conclusion of this pilot study was the following: there is a need to identify nurses' experiences with Muslim patients in countries where there is a large Muslim population so we can provide needed education.

Conducting Interviews with Study Participants

This researcher decided to conduct virtual interviews with the study participants, and this decision was in line with current events related to the COVID pandemic. According to Braun and Clarke (2013), virtual interviews are no longer a weak way to collect data from participants. On the contrary, they have benefits that may serve the researcher and participants in the study at the same time. It is considered a convenient way to collect data and is empowering for the study participants. They can participate in their comfort zone with no need to bear the burden of a face-to-face meeting. Additionally, virtual interviews allow participants to better maintain their anonymity. For the researcher, the virtual meeting is suitable for discussing sensitive topics with participants. The researcher can conduct more than one interview in the same day without the effort of a face-to-face meeting (James & Busher, 2006; Meho, 2006). The researcher may face disadvantages while conducting the interview, for example, the length of the virtual interview is longer compared to a face-to-face meeting, and the researcher may have difficulty building trust with the participants (Braun & Clarke (2013). Before conducting the interview, each participant received and read an online information sheet (Appendix A), which provided detailed information about the study. Reading the information sheet was considered their consent to participate in the study. Opening the interview is an important step, and the researcher emphasized that there is no right or wrong response before asking the participants questions. Then, the researcher followed the interviewing process based on the interview guide to ensure each question was answered sufficiently. The researcher is responsible for navigating the conversation and directing the participants to stay focused on the topic. The researcher showed interest in engaging the participants and used silence to give the participants a chance to speak freely (Braun & Clarke, 2013). Generally, open-ended questions in the semi-structured interview

are a flexible approach, which leads to building rapport with participants, and it eases boundaries (Kallio et al., 2016). Field notes were taken by the researcher during the interview. Additionally, the researcher utilized a digital recording device to maintain the data.

Data Analysis

The analysis of phenomenological data is determined by understanding the meaning of the data, personal experiences, and cluster of the phenomena in a particular situation (Phillips-Pula, 2011). The researcher started with a transcription of the digital recording immediately after each interview. The transcript was reviewed by the researcher. Each transcript underwent a deep-reading process, which helped the researcher digest and absorb the information and gain a full understanding of the content. To provide rigor to the study, the researcher supported the analysis with the "bracketing process." This process is considered an important step in phenomenological descriptive studies (Ahern, 1999). It aims to protect the data from the researcher's perceptions about the phenomena being studied. It is applied before and during the interview to extend the data analysis. To apply the bracketing process, the researcher used the writing memos technique throughout data collection. This technique helps the researchers to acknowledge and foreground their preconceptions (Tufford & Newman, 2012).

A modification of Colaizzi's method of data analysis was adopted in this study. The method was developed in 1978 and modified in 2007 by Creswell and Clark. Colaizzi's method includes steps built in a sequence (Creswell & Clark, 2017). According to Morrow et al. (2015), there are seven essential steps the researcher has to follow to apply Colaizzi's method of data analysis. The first step is called familiarization, and in this step the researcher starts reading the transcripts, and the researcher concentrates on each interview separately and intensively. The second step reflects the researcher's work on identifying significant statements. Therefore, the

researcher highlighted the phrases and statements that explain the nurses' experiences. In the third step, the researcher formulated the meanings of the selected statements, which are related to the phenomena being studied. Then, the next step is organizing the important phrases and statements in groups or themes. Next, the researcher combined all of the phrases and statements from the previous step to write an inclusive and complete description of the phenomenon. In this stage, which is the last before the final step, the researcher wrote a precise and brief description that includes the important aspects related to each theme, which produced the initial fundamental structure. The last step in the analysis process seeks to return the structure to the participants to ensure the structure represents their experiences (Morrow et al., 2015).

Trustworthiness

To enhance the trustworthiness of the data in this study, the researcher followed different validity procedures that match qualitative research. The researcher worked with the committee chair as a non-Muslim, U.S. nurse researcher to assure the accuracy and credibility of the data analysis. Additionally, using a rich description helped the researcher add validity to the data. In the same context, providing an external auditor may help the researcher assess the whole project and evaluate the project process (Creswell & Creswell, 2017). According to Goffman (1959), reliability in qualitative research is based on a willingness and truthfulness produced while collecting the data from study participants (Goffman, 1959). For this study, the participants were voluntary, and they had knowledge of that fact. Additionally, reviewing the transcripts is important to check reliability and to confirm the transcript is free from any mistakes that may occur during transcription (Creswell & Creswell, 2017).

Ethical Consideration

The Institutional Review Board (IRB) approval was obtained from the University of North Carolina at Greensboro (UNCG) before beginning the study. Participation in this study was voluntary, and each participant had the right to leave the interview at any time during the data collection stage. Also, research participants could decide after the interview to not participate. In this case, the researcher would have had to destroy the data. Guidelines for human protection were included in the information sheet, so each participant read them before the interview was conducted. Additionally, each participant was informed of the risks that may occur during the interview, including some psychological issues, such as embarrassment. It would be rare that a nurse would experience embarrassment in discussing the care of Muslim patients because nurses are used to caring for patients of different ethnic backgrounds and cultures. If embarrassed, the nurse could take a short break, stop the recording for a brief time, or stop the interview. The interviewer would sit quietly to allow time for the embarrassment to subside. Confidentiality was maintained for all participants and study data. The participants' names were not recorded. If any identifying information is stated in interviews, it was not transcribed (left blank). The interviews were immediately transcribed by the researcher, and once the transcript was validated, (Zoom) recordings were erased. All transcripts were identified by a number only. The transcripts were stored in the UNCG Box. Transcripts will be kept for three years based on IRB protocol.

Because of the low-risk nature of this study, there was no need for signed consent. Participants read the consent and received a copy. Potential participants were registered nurses who self-identify as having cared for Muslim patients in a hospital setting. No identifying

information was asked of the participants. Once the interviews were transcribed, the subjects were identified by a pseudo-name.

Summary of Chapter III

This chapter described the methodology of the research including the research design and the phenomenology approach that was used to describe the lived experiences of study participants. In addition, setting, description of the sample and data collection and analysis were all introduced.

CHAPTER IV: FINDINGS

The purpose of this study was to explore the lived experiences of non-Muslim hospital employed registered nurses providing care for Muslim patients in the United Sates. The overall question answered by the participants is the following: What are the lived experiences of hospital registered nurses providing care for Muslim patients in the United States?

Study Participants

Through snowball sampling, data saturation occurred after 10 participants completed in-depth one on one video recorded interviews. Each participant was interviewed once and interviews lasted 39 to 61 minutes with an average of 52 minutes. Two participants identified as male (20%), and eight participants identified as female (80%). For ethical/racial identity, three (30%) were African American, and (70%) were white. Three participants (30%) had a master's degree in nursing, and seven (70%) had a Bachelor of Science in Nursing. Years of nursing experience ranged from 8 to 26 years. All of the participants had direct experience caring for Muslim patients and they represented different hospital organizations in four different states including (North Carolina, Texas, New York, and Massachusetts).

Findings

See Table 1, the interview transcripts were coded and categorized. This process revealed three major themes: Nurse-Patient Relationship, Nurses' Knowledge and Western Healthcare, and Family Influence. The themes are further discussed below.

Table 1. Themes, Categories, and Codes

Theme	Category	Code
Nurse- patient Relationship	Building a Relationship with Muslim Patients	*Gender Influence* *Privacy and Modesty* *Religious Practices* *Communication Challenges* *Stereotypes* *Implicit Biases*
Nurses' knowledge and Western Healthcare Systems	Nurses' Knowledge of Islamic Culture	*Lack of Knowledge*
	Providing Healthcare to Muslim Patients under the Umbrella of Western Healthcare Systems	*Raising Awareness* *Diversity Training* *Characteristics of Western Healthcare Systems*
Family Influence	The Advantages and Disadvantages of the Kinship	*Family Involvement* *Male Authority* *Family Support*

Theme I: Nurse-Patient Relationship

The first theme is the largest theme since it focuses on the nurse-patient relationship which is the center of nursing care. All of the nurses spoke about the nurse-patient relationship with Muslim patients and their roles as the direct caregiver for hospitalized patients. A wide variety of topics were discussed including gender and privacy issues, patient autonomy and decision-making processes, Muslim religious practices, communicating with Muslim patients and stereotyping. These are presented below.

Participants spoke of the importance of the gender of the healthcare provider when caring for Muslim patients, particularly female patients, and the need for female healthcare providers. "Muslim patients tend to ask for female providers," and this request is not limited to their nursing care but extends to physicians and other medical providers. Four participants discussed that while it was easy to assign female nurses to female Muslim patients if they request them, it was more difficult to have a female doctor available at all times. Participants stated that the availability of female providers such as surgeons and anesthesiologists "was a challenge" for the nurses and patients themselves. The patient is in a difficult decision-making position as to whether they were going to accept care, or a procedure and the nurse is also affected. As one participant said, "There was a challenge for me, just kind of waiting on them to decide." Additionally, participants recognized that the need for female providers created stress for Muslim female patients with one participant stating "It's been hard for them [patients].

The healthcare provider gender preference of Muslim patients can also be difficult for nurses, especially male nurses. One male participant stated that it was "an unpleasant feeling" and that he didn't "feel comfortable" with these requests. Additional comments were made concerning caregiver gender preference of Muslim patients. One participant stated that gender preference as a patient's priority was never considered until after taking care of Muslim patients. The participant stated, "I learned as I kept getting Muslim patients." Participants mentioned that being assigned a female Muslim patient makes nurses think of many things related to their culture. This is highlighted by a participant stating, "It literally starts when she walks through the door."

The participants in this study recognized the importance of providing equal care in the nurse-patient relationship. Participants discussed their concerns about providing unbiased care

for Muslim patients when their requests for female providers were not honored. A participant stated female Muslim patients "expect that care to be given by women" and failure to comply with their request is "not fair." Another participant gave the example that sometimes female Muslim patients have only one option for a female provider to deliver their baby, and most of them go to that provider because it is the only option available. The participant added, "it was not the practice that I would have chosen."

Many participants noted that privacy is high among Muslim patients, especially for women. One participant stated that it is "difficult to reach the subject of sexuality which is really important" in some cases. Another participant confirmed that there is a "high sense of privacy" amongst Muslim patients, and confidential health information reaches the family of the patient, including the mother or husband. Therefore, she always had to be careful "to maintain a good privacy." One participant felt that modesty is what leads female Muslim patients to have a high sense of privacy. The participant mentioned that not every nurse knows about this cultural difference; therefore, "If I see somebody else that I feel is not being respectful enough or going the extra mile, I will let them know." Another participant stated that privacy and modesty in Muslim female patients make nurses adopt many adjustments in nursing care "…I am doing everything I can possibly do to create modest environment."

Many participants discussed different religious practices of Muslim patients as important in the nurse-patient relationship. Knowing those practices lead nurses to be "culturally sensitive to their needs." Food preferences for Muslim patients are considered very important as one participant said, "they tell us they are Muslim and tell us their diet is special." The food options available to Muslim patients in the hospitals may also be "limited." Three participants openly discussed that the food served in the hospital is "not appropriate" for Muslim patients. It may

contain “meat, including pork”, and this is “not acceptable” for Muslim patients. One participant mentioned that hospitals needed to “embrace the food preferences” of Muslim patients and provide a “special menu.” Another aspect that was highlighted by some participants is that Muslim patients have some religious restrictions regarding some medications. This is highlighted by one participant stating, “There are some certain medications that can’t be given” because it contains “gelatin.” In addition, one participant discussed those Muslim patients have different beliefs about the placenta, and “they want to save the placenta for some sort of religious practice.” Nurses were not aware of this practice and they “put it in formaldehyde.”

Another religious practice that was discussed related to the nurse-patient relationship was prayer. Muslim patients “may pray multiple times throughout the day.” Many participants expressed their readiness in helping patients to perform prayers. As one participant said, “I was happy to do so.” Other participants have found that helping patients to perform prayers may be considered an extra burden on the nurse because “they take a long time,” therefore “we arrange schedules around their prayers.” Three participants discussed the importance of spiritual practices to the healing process. As one participant said, “prayer is essential for some people’s lives and that’s part of healing and this part of care.” another participant added, “… I feel good when I help a patient bring some religious practices into the healthcare system.”

Communication was one of the most important topics raised by the participants in the study. Many participants discussed the strategies they used to build trusting relationships with their Muslim patients. Building trusting relationships with Muslim patients was considered a "challenge" because it requires more time than typical. As one participant stated, “We need to be given a lot more time to gain rapport and trust with everything.” She continued, “…we are not given enough time to really establish the trust.” Respecting cultural differences is adopted by

some participants to build trust with Muslim patients. One participant stated, “I gain their trust by respecting what the patients believe,” which suggests that respecting cultural differences helps nurses accommodate patients’ differences. Many participants discussed that asking Muslim patients questions was a helpful tool to know more about their needs to build a trusting relationship. Participants stated, "I ask questions" and "I just try to listen,” which help to create a "safe space" for patients to talk about their religious and cultural needs. Another participant stated, "I try to be sensitive" to their religious needs and “I just feel like acknowledging and seeing who they are.” Some participants mentioned that showing “acceptance, compassion and empathy" helps nurses to “have those more intimate conversations" with their patients. However, feeling uncertainty while communicating and providing care for Muslim patients is another aspect that was discussed by some participants. Nurses try to find a balance between the patient's wishes and what the nursing care requires. As one participant said “… you're uncertain because you always try to take care of the patients and try to respect their wishes and try to give the tailor to things." To overcome that feeling of uncertainty, nurses “try to work as a team," and raise the awareness among nurses by “helping the staff to know and understand why patients might have certain expectations.”

Communicating with Muslim patients who can’t speak English was frequently mentioned by the study participants. There are different channels used by nurses to communicate with patients including language line, interpreters, and online translation. Participants discussed the process of communication and how it impacts nursing care. According to two participants, “it’s very difficult" and "it is time consuming." Another participant mentioned that "… it can be a little bit challenging, especially when you have so many tasks to take care of.” The difficulty in using it is that there is an intermediary between the nurse and the patient, and the information

and questions may not reach the patient correctly. As one participant said, “it gets tricky… you want to make sure they are getting factual information and not the wrong information, because I don’t know what they are saying.” In addition, “it takes a lot more time,” said one participant who gave an example about collecting consent from Muslim patients through an interpreter. The same participant mentioned that it can “easily take half an hour,” and some nurses do a quick consent without a full explanation. Some participants described their reactions when using the interpreters to engage in the process: "I make eye contact with my patients, and I definitely read my patients and what they are saying with their bodies.”

Finally, stereotyping of Muslim patients was another topic that was discussed by the participants. Some of the participants acknowledged the existence of negative stereotypes about Muslim patients, while others denied it saying, “I haven’t seen it.” Two participants reported their implicit bias, saying “I’m quite sure that there are implicit biases that I have.” Another participant described the experience of fixing implicit biases towards Muslim patients by doing “a lot of internal work.” Participants provided some examples about stereotypes observed in the hospitals. One participant said, "… other nurses requesting to not have Muslim patients, which I feel it’s inappropriate" because “they deserve equal care.” Another participant mentioned that there are some “negatives" comments about Muslim patients regarding how “the husband is speaking for the patients," their "head wrap," and “their foods." Participants reported a negative impact of patient stereotyping on nursing care. Stereotyping caused “a barrier in communication” and nurses can’t meet the patient’s needs. Additionally, one participant suggested that it impacts the relationship between the patient and the nurse, “They [patients] don’t trust you [nurse]." One participant mentioned that failure to respect the patient's culture and demands impacts nursing care, so the “patients are not receiving nondiscriminatory care."

Participants suggested different practices and strategies that might help them while caring for Muslim patients. Their suggestions included “providing religious people" in the hospitals to support Muslim patients. Also, nurses need "some representatives from the Muslim community" to provide some education about Islamic culture and the needs of Muslim patients. Some participants suggested providing “Arabic interpreters" instead of using online translation. Moreover, creating a “survey for Muslim patients” to fill out before their discharge would help the hospital identify weaknesses in providing culture care to the patients. Hiring “Muslim coworkers [nurses and doctors]"is considered an effective strategy to raise awareness about Muslim patients' care. In addition, reporting offensive behaviors against Muslim patients may help to identify the stereotypes, as one participant stated “opening up the floor to report behaviors that we feel are offensive to cultures" is considered important.

Theme II: Nurses’ Knowledge and Western Healthcare Systems

The second theme that emerged was Nurses Knowledge, specifically related to Islamic culture, and Western Healthcare Systems. First, nurses’ knowledge about Islamic principles and cultures was discussed by the study participants. The majority of the participants reported that there is a “lack of knowledge" about Islamic culture, as one participant stated, "I don’t have enough.” Some participants knew about "dietary preferences," and “prayer in Islam.” Another participant knew about a “Holy book" and “Ramadan.” Many of the participants agreed that the lack of knowledge does not help them in providing “transcultural nursing care" for Muslim patients. In this regard, many participants reported that hospitals may provide them with information about culture diversity through “web pages" and “online education modules" but there is “no specific knowledge about Muslim patients." Another participant added that diversity training is provided about how to respect cultures however, “it doesn’t give education or how it

relates to your practice." Therefore, many participants found that asking Muslim patients about their religious and cultural practices raised their awareness about Muslim patients' needs. They also mentioned that they do "independent research" using an online database.

Receiving healthcare for Muslims under the umbrella of Western healthcare systems was discussed by the participants. Most participants agreed that Western healthcare systems do not meet the unique needs of Muslim patients. There were various reasons behind this issue mentioned by participants. One participant suggested, "The whole healthcare system is so fragmented," and there is no guarantee that minorities will receive culturally congruent care. Another participant mentioned that medical providers focus on the system's requirements, thus, there will be a distraction from the needs of the patients. This participant added that "The systems are set up for more American kinds of tradition" and "the systems are big, and they are not meant to help individuals." The statement was furthered by noting that the healthcare system has certain rules, and the patients "have to go along with that." Another participant added on to this point stating, "Our policies are like the path to do it at this time. Otherwise, you get penalized." Another participant reported that healthcare systems should encourage adopting "patients' centered care" which helps to deliver culture care for the minorities by knowing their culture concerns. Two participants discussed how the Western healthcare system as a whole is "rushed," "everything is rigid," and "patience is just not a part of our routine." Moreover, some Muslim patients "do require a little bit more time" which is not always available. On the other hand, one participant suggested that it is not about the healthcare system, but it is about the individuals who providing care for the Muslim patients. "The system can have everything in place to make it right… but the individual has to be willing to provide culture sensitivity care to the patients." Another participant believed that the western healthcare system meets the unique

needs of Muslim patients, but “there’s always room for improvement." Additionally, some participants suggested methods for improvements by saying, “Our hospital systems need to have some type of diversity training,” and “There needs to be cross-cultural education and there need to be modules on the major ethnicities and how to care for them.”

Theme III: Family Influence

The third theme focuses on family influence when providing care to hospitalized Muslim patients. Family is an important concept for Muslim patients. Participants discussed the impact of the family on the patient in terms of emotional, social, and psychological aspects. Several participants noted that “families are always very supportive" and “involving the family is essential, is very important." Many advantages reported by the participants show the positive impact of the presence of Muslim families. Two participants mentioned that Muslim families know their patients very well, and medical providers can depend on them to “understand the patient’s conditions" when the “patient is unresponsive." Nurses use family to get “medical history" and they always trust it. Also, the admission procedure becomes “easier" because of the presence of the family. One participant stated that “you get to understand your patient better because you’re talking to the family, " and "they can give you some insight to know the best for the patients." Families help nurses to raise their awareness about “culture needs” of the patient, which leads them to “accommodate patient’s preferences." One participant mentioned that families support patients to do the religious practices which impact “positively on patient’s care." Another participant discussed how families who are "the communicators for the patients" easily report the patients’ needs. Some participants discussed the huge emotional support that was provided by the families to the patients. One participant stated, “it’s nice to know that a patient has such a support system,” exemplifying this idea.

In addition to the positive aspects of family influence, the study participants also discussed a number of challenges related to the influence and direct presence of Muslim families. Family also factored into patient autonomy and decision-making processes. Participants noticed that men control the decision-making process with most female Muslim patients. As one participant stated, "… women don't speak as sometimes the men will do the speaking for them instead of the women answering, the men will speak." Another participant discussed that Muslim patients do not discuss matters in the presence of their husbands. Husbands discuss and decide, and "they don't [the women don't] really respond, their husband responds." Another participant indicated that she always tries to retain attention to the patient, but somehow the focus returns to the husband and his decisions. "I could easily just direct my attention to the husband" suggesting it is clear that he is responsible for making the decision. Two participants emphasized that "The presence of the patient is important in the decision," therefore, decisions are always confirmed by the patient herself, even with the presence of the husband. Another participant clarified that she always defends the right of the patient's autonomy to make decisions because, "the patient is the decision maker here." Some of the participants discussed that they do not violate this method of decision-making because it is part of their culture and "this was a lifestyle." However, another participant was against this, and she said, "… you feel like you're always making a mistake."

Another difficulty that was mentioned concerning family influence was that Muslim families ask, " questions which takes more time" and "… that can be make it more difficult for nurses." Additionally, in some cases, "family members are being adversarial or against the patient" and "they're interfering with what the patient wants." Therefore, participants stated that nurses try to protect the patient's right to speak privately, and they "ask people to step out." Patient needs and goals may not always coincide with the family's motives which leads to

having “some sort of conflict." This was suggested by another participant's comment that a “patient's goals may not always be in line with the family's goal." Participants stated that nurses follow the patient's opinion and not the families. One participant stated, “They [the family] are not my patient."

Finally, another issue noted with Muslim family influence is that they have too many visitors for one patient. The presence of many visitors “does slow down nursing care,” and, "it can get pretty crowded, which might be uncomfortable for people." In addition, some families prefer to be the interpreter for their patients, as mentioned above. While this is an option, some nurses may not want this and prefer to use interpreters from the hospital or translation devices. One participant explained that "…their [families] translation might sometimes influence the information that's being communicated."

Summary of Chapter IV

This chapter has identified the findings of this study. Nurses’ experiences caring for Muslim patients form different themes, including Nurse- Patient Relationship, Nurses’ Knowledge and Western healthcare Systems, and Family Influence.

CHAPTER V: DISCUSSION AND IMPLICATIONS

Discussion

The purpose of this study was to describe and explore the lived experiences of non-Muslim, hospital employed registered nurses providing care for Muslim patients in the United States. As discussed in the previous chapter, three major themes emerged from the participants' narratives. Nurse-patient Relationship, Nurses' Knowledge and Western Healthcare Systems, and Family Influence. The purpose of this chapter will be to discuss the study findings as well as to present study limitations.

Nurse-Patient Relationship

The first theme, Nurse-Patient Relationship highlighted the relationship nurses have with their patients. The nurse-patient relationship is at the heart of nursing care and is essential for providing safe and effective care (Manley et al., 2019). In order to develop these relationships and promote patient-centered care, the nurse must have the necessary skills and knowledge to connect and understand their patients' unique needs (McCormack & McCance, 2017). The participants in this study validated the importance of the nurse-patient relationship in their provision of care to Muslim patients.

Gender was one aspect of the nurse-patient relationship that was identified as significant. Female Muslim patients were suggested to prefer receiving medical care from female providers. In another similar study, a significant number of Iranian patients indicated their negative attitude towards receiving nursing care from a nurse of the opposite gender (Sharifi et al., 2021). It is important to highlight this aspect, which may negatively affect both the experience and the relationship of the nurse with the patient. Accordingly, there are facilitators that have been mentioned in the literature to improve the nurse's relationship with patients of the opposite

gender. These include preventing misunderstandings, considering individual context, and not violating boundaries (Vatandost et al., 2020). There are, however, limitations to this approach. The participants of this study addressed the availability of medical providers that match the patient's gender and providing unbiased care in the nurse-patient relationship. This case demonstrates that although the ideal scenario is to consider the patient's cultural needs, it is sometimes a challenge. Availability of an adequate number of health care providers appropriate with the patient's cultural requirements may contribute to the provision of equitable care. One possible implication of not providing nurses of the same gender for Muslim patients is negative health outcomes. For example, if the patient does not accept the care, they could go untreated. According to the participants in the present study, female Muslim patients want same gender healthcare providers, but this is not mentioned for male Muslim patients. Similarly, a study conducted in Saudi Arabia in 2013 reported that non-Muslim nurses' experiences with Muslim patients found that male patients had no opposition in accepting nursing care from nurses of any gender (Alosaimi, 2013).

Communication is the link between the patient and the nurse, so communication may be directly affected by the difference in culture. In this case, the participants in this study claimed that communicating with Muslim patients often requires additional time, which contributes to increasing the burden on the nurse. Looking at the literature, time is a common factor in inhibiting the development of effective nurse-patient communication and provision of quality care. In a study that highlighted the factors that hinder communication between patient and nurse, lack of time was the most important factor expressed by nurses (Ardalan et al., 2018). Based on the results of this study, time is an important factor in improving the quality of nursing care, especially with the presence of cultural differences and language barriers. Language

barriers are a catalyst for ineffective communication between the patient and the nurse. The nurses in another study done in Sweden explained the strategies used to overcome language barriers, including the use of translators, and the consequences of that (Alm-Pfrunder, 2018). In addition to the lack of time, which may not give nurses an opportunity to increase the efficiency of nursing care, there are other important aspects. Lack of patient privacy is exchanged for improved communication with patients when interpreters are used. This may negatively affect the nurse-patient relationship, which is considered the first step in nursing care. Leininger (2006a) also recommended in the theory of culture care that some cultural aspects which the patient bring to health care are preserved in proportion to the nature of nursing care. Alternatively, it can be negotiated and restructured in a framework that suits the patient and the nurse.

In addition, the participants of this study discussed the impact of stereotyping on Muslim patients. While most nurses believe they do not stereotype patients and treat everyone the same, nurses in other studies addressed being subject to implicit biases with some vulnerable populations such as aged and overweight patients (Schroyen et al., 2016, Waller et al., 2012). In this study, it was suggested to open the door to discuss the issue of stereotyping. Alspach (2018) states that while the formation of stereotypical biases is a normal part of human cognitive development, implicit bias can be minimized by self-reflection to become more aware of biases and control strategies such as perspective-taking and seeking common-group identities. Implicit bias training as a tool should be added for nurses as a network meta-analysis of 492 implicit bias studies (Forscher, et al., 2019) found that implicit bias can be changed, although educational effects are weak and must be continually reinforced. This research demonstrated that

stereotyping of Muslim patients is present in healthcare systems. Studies discussing this aspect are lacking, making this finding valuable for future studies.

Nurses' Knowledge and Western Healthcare Systems

The participants in this study discussed that their knowledge in providing nursing care for Muslim patients is limited and may not be sufficient to be culturally competent. In one study done in Slovakia, the percentage of nurses who self-reported they are very culturally competent when providing nursing care to patients from other cultures did not exceed 28% (Cerveny et al., 2020). Another study done in Iran among nurses working in teaching hospitals evaluated the status of cultural care among nurses and found that cultural care and nurses' cultural attitudes were at a poor level (Firoozi et al., 2020). Being unprepared to provide care based on a patient's culture may lead to consequences that impact patient outcomes. Nurses in a study conducted in Norway involving 30 nurses reported mismanaging some nursing care with ethnic minorities because of their own lack of knowledge (Debeasy et al., 2014). Literature shows other consequences of a lack of culturally competent skills such as lack of confidence in working with minorities and emerging feelings of uncertainty (Wong et al., 2017). According to Leininger's theory, nurses should focus on emic and etic concepts when providing care to diverse patients. As a result, they will be able to recognize their professional knowledge and identify patient internal knowledge. Applying transcultural nursing care can potentially guide nurses and improve experiences when caring for patients with different cultural backgrounds. Nurses need continuous training to be able to embrace cultural competence. Thus, with such training the nurse can determine what is lacking in the direction of giving care to patients from different cultures, and what exists and needs to be developed. In addition, participants in this study added that the Western healthcare systems may not meet the unique needs of Muslim patients. In general, there

is room for improvement to involve the needs of minorities, including Muslim patients. This finding could be taken into consideration in future nursing program development. Additionally, future research could benefit from exploring this topic.

Family Influences

According to the study participants, family is sometimes seen as a hindrance to nurses who are caring for the patient. One reason for this is Muslim families sometimes visit for long hours and in large numbers. On the other hand, the dominant role of family was also seen as an aid. Families support the patient both emotionally and spiritually. In one study conducted to examine the family's involvement with patient care, the nurses explained that there is an intersection between the requirements of nursing care and the requirements of the family, but there may be no outputs for this intersection due to some environmental and organizational factors (Hetland et al., 2018). Families may have various requests, which the nurses may not be able to fulfill due to lack of time or resources. Family involvement in patient care requires multiple levels of engagement (Mackie et al., 2020). Therefore, while Western healthcare systems emphasize "patient centered care," family participation also needs to be included in health policies to raise the voice and viewpoints of families regarding their involvement in the patient care, regardless of the motive behind it, whether it is religious, cultural, or perhaps an emotional or social motive. The participants in this study have explained the support provided by families to patients, and the patient's needs, especially religious and cultural ones. This information is known through talking to the patients' families. While there may also be an aspect that bears a negative impact on some patients, such as the conflict between the patient's desire to agree with the family and the desire to decide on behalf of the patients themselves, families need to be included when caring for Muslim patients. Finally, culture care theory emphasizes that

social structure factors including kinship and social relationships have direct and indirect influences on health and wellbeing.

Another challenge discussed by the participants of this study was the male authority regarding decision making for female Muslim patients. Lacking decision-making capacity directly impacts the patient's care. Of course, there are medical cases that require patients to waive their right to make health decisions, such as may happen with patients who suffer from chronic mental illnesses (Blanck & Martinis, 2015). In some cases, though, the inability to make decisions is unrelated to patient health conditions. The control of cultural traditions in some societies may prevent women from making health decisions that concern themselves. Therefore, men dominate the decision-making process, and this may not be considered appropriate in Western health systems, which gives patients full autonomy to make their own decisions. This aspect has been demonstrated in the literature; for example, Mboane and Bhatta (2015) clarify the negative impact of husbands in making the decision for Mozambican women regarding contraceptives. Some of the participants in this present study have also opposed the decision-making process within Muslim families, and some have stated that it is a cultural matter due to the nature of Islamic culture. Accordingly, the presence of a health model for Muslim patients may contribute to understanding this differing culture and may allow the nurses to protect the patient's right to make decisions in a way that does not affect the culture and conviction of Muslim patients.

Eastern culture of Muslim countries adopts the principle of collectivism as a significant aspect of daily life. This principal also shapes family dynamics. A study was done in Saudi Arabia with the aim to explore non-Muslim nurses' experiences caring for Muslim patients. The study mentioned that the decision-making process is overruled by the family members of Muslim

patients regardless of the patient's gender (Alosaimi, 2013). In this study, the situation is similar; however, in the U.S., where patients are not likely to have extended family present, husbands control the decision-making process for their wives. Therefore, it appears that men control female patient autonomy.

Implication of Nursing Research

Because this was a small qualitative study conducted at one point in time, there is a need to conduct studies with more diverse sample using maximum variation sampling. This may contribute significantly to understanding broader aspects of hospital nurses' experiences with Muslim patients. These studies may be conducted within the United States of America or other countries where there is not a large Muslim population. These experiences of nurses could then be compared and contrasted to existing literature from majority Muslim countries. It is also vital to study the experiences of Muslim patients receiving healthcare within the Western health systems. These experiences may contribute to the development of health models of care for Muslims. The number of health models could be expanded depending on the type of care. For example, developing a model for maternal nursing care specially for Muslim patients based on the perceived needs of these patients could increase the quality of care. In addition, the lack of knowledge that nurses suffer from requires an increase in the number of educational interventions that contribute effectively to raising health awareness about the nursing care of Muslims.

Implication of Nursing Education

Nursing schools historically have discussed the importance of cultural competence. The new American Association of Colleges of Nursing (AACN) has updated their core competences of nursing education in 2021. The AACN explicitly states the critical "concept" of diversity,

equity, and inclusion. This concept defines diversity as “a broad range of individual, population, and social characteristics, including but not limited to age; sex; race; ethnicity; sexual orientation; gender identity; family structures; geographic locations; national origin; immigrants and refugees; language; any impairment that substantially limits a major life activity; religious beliefs; and socioeconomic status.” Despite these written guidelines, there is no practical application that would truly adequately prepare the nurse in taking steps when dealing with diverse patients. There is a gap between the educational material and practical training for nursing students. One way to address this could be by using scenario based learned methods in which nursing students are given common scenarios and asked to demonstrate their response. The reality may be different in hospitals than in nursing colleges, so it should be taken into consideration to provide detailed educational material regarding minorities in the provision of health care based on the references. It is recommended to bring representatives from these minorities to talk to nursing students about their religious and cultural requirements. As stated earlier, enhanced education is also needed on overcoming implicit biases.

Implication of Nursing Practice

Hospital nurses need training that is specific to each minority, rather than a single training that might include general overviews of different cultures. These training sessions must be periodically available to the nurses with annual assessments of the nurses towards the provision of cultural care. Based on these evaluations, weaknesses may be identified in order to be able to improve them. Nurses must be aware of how cultural competence improves quality of patient care. Indeed, Delgado and colleagues (2013) increased the cultural competence of hospital nurses by developing a one-hour core class developed to increase awareness of how cultural competence impacts quality of care. Finally, there is a critical need to increase the racial

and cultural diversity of the nursing workforce to match the diversity of the U.S. population. According to the American Association of Colleges of Nursing, the percentage of minority nurses in the U.S. will not exceed 19% of the registered workforce in nursing (American Association of Colleges of Nursing [AACN], 2019) yet initial findings of the 2020 Census demonstrate (U.S. Census Bureau, 2021) that the White population, while still the largest race/ethnicity in the U.S., decreased by 8.6% to 60.1% of the population since 2010. A diverse nursing workforce is critical to the provision of culturally congruent, quality of care.

Limitations of the Study

The researcher is Muslim; thus, the study may be subject to bias. The researcher did bracket and was sensitive to this matter throughout the data collection and analysis process. A non-Muslim, U.S. nurse researcher also reviewed and verified data analysis. Since the participants of this study were from limited states, results may not reflect the lived experiences of other nurses in other geographical areas/ organizations of the United States. The researcher had only white and African American nurse participants, who were highly educated. Additionally, the researcher was Muslim so participants may have tried to answer questions to be culturally appropriate instead of fully honest. Also, though data saturation was achieved, this study had a small sample size considering the varied practice environments of hospital employed nurses.

Conclusion

This chapter has discussed the major themes of this study, including Nurse-patient Relationship, Nurses' Knowledge and Western Healthcare Systems, and Family Influences. The findings are in line with the existing literature. Moreover, this study has added to the existing research in this field. The first theme in this study reveals the relationship of the nurse with the patient and its significance, which is known to directly affect patients' outcomes and their health

status. What stood out in this study is that participants overwhelmingly identified the gender of the health care provider as an influential factor when caring for Muslim patients. Across various hospital settings where study participants were employed, female Muslim patients commonly request female health providers. Muslim patients were also described as highly private which likely is related to their apprehensions related to gender, and thus nursing care is affected by this modesty. With this knowledge, nurses and healthcare facilities should be prepared with an understanding of female Muslim patients' potential expectations. In addition, participants identified the importance of providing equitable care to Muslim patients. Patient autonomy is clearly limited in female Muslim patients and is influenced by the authority of males. Communication with Muslim patients was also found to be influenced by their culture and the participants realized that time is an important, and limiting factor in communication. If the nurse's workload were reduced, time would be less of an issue and provide more opportunity for culturally competent care in this case. This study also shed light on stereotyping against Muslim patients, which is less commonly discussed in the literature, making this study an interesting contribution to the field. Overall, more cultural awareness could resolve confusion and misunderstandings for nurses working with Muslim patients.

The second theme uncovered the nurses' lack of experience with and knowledge of Islamic culture and its impact on the health and illness of Muslim patients. The participants expressed their need to attend training classes, which may contribute to increasing and diversifying the knowledge of Islamic culture and its application within the health system. According to the study participants, Western health systems are not meeting the cultural and religious needs of Muslims patients. It is possible that this finding is valuable for future research and nursing program development.

The last theme in this study reflects the influence of the Muslim families. Opinions differed between the positive and negative influence in the presence of families with Muslim patients. It appears that the positive can outweigh the negative in most cases. As Muslim family involvement is not sufficiently discussed in the literature, it is reasonable to suggest that it would be beneficial to explore this topic further.

As the number of Muslims living in the United States continues to rise, current health-care practices in regard to Muslim health require more consideration. Thus, raising awareness among nurses may greatly contribute to embracing the needs of Muslim patients. This may be through theoretical and practical educational sessions. Nurses dealing with Muslim patients may need more time to meet the needs and to improve communication, which is the cornerstone of nursing care.

REFERENCES

Abudari, G., Hazeim, H., & Ginete, G. (2016). Caring for terminally ill Muslim patients: Lived experiences of non-Muslim nurses. *Palliative & Supportive Care, 14*(6), 599-611.

Ackley, B. J., Swan, B. A., Ladwig, G., & Tucker, S. (2008). Evidence-based nursing care guidelines: Medical-surgical interventions. (p. 7). St. Louis, MO: Mosby Elsevier.

Ahern, K. J. (1999). Ten tips for reflexive bracketing. *Qualitative health research*, *9*(3),407-411.

Ahn, J.-W. (2017). Structural Equation Modeling of Cultural Competence of Nurses Caring for Foreign Patients. *Asian Nursing Research, 11*(1), 65–73. https://doi.org/10.1016/j.anr.2017.03.001

Al Dasoqi, K., Zeilani, R., Abdalrahim, M., & Evans, C. (2013). Screening for breast cancer among young Jordanian women: ambiguity and apprehension. *International nursing review, 60*(3), 351-357.

Ali, P. A., & Johnson, S. (2016). Speaking my patient's language: bilingual nurses' perspective about provision of language concordant care to patients with limited English proficiency. *Journal of Advanced Nursing, 73*(2), 421–432. https://doi.org/10.1111/jan.13143

Almutairi, A. F., Adlan, A. A., & Nasim, M. (2017). Perceptions of the critical cultural competence of registered nurses in Canada. *BMC Nursing, 16*(1). https://doi.org/10.1186/s12912-017-0242-2

Alosaimi, D. (2013). A Phenomenological Study of Non-Muslim Nurses' Experiences of Caring for Muslim Patients in Saudi Arabia. *International Journal of Arts & Sciences, 6*(2): 637-646.

Alosaimi, D. N., & Ahmad, M. M. (2016). The challenges of cultural competency among expatriate nurses working in Kingdom of Saudi Arabia. *Research and Theory for Nursing Practice, 30*(4), 302-319.

Alpers, L.-M., & Hanssen, I. (2014). Caring for ethnic minority patients: A mixed method study of nurses' self-assessment of cultural competency. *Nurse Education Today, 34*(6), 999–1004. https://doi.org/10.1016/j.nedt.2013.12.004 Loo

Alspach, J.G., (2018). Implicit bias in patient care: an endemic blight on quality care. Critical Care Nurse, 38(4), 12-15.

AlYateem, S., & Al-Yateem, N. (2014). The experience of overseas nurses caring for Muslim patients in Kingdom of Saudi Arabia and UAE: a qualitative study. *International Journal of Research in Nursing, 5*(1), 17.

American Association of Colleges of Nursing (2021). The Essentials: Core Competencies for Professional Nursing Education. Available at: https://www.aacnnursing.org/AACN-Essentials

American Association of Colleges of Nursing. (2019). Enhancing Diversity in the Nursing Workforce [Fact sheet]. Retrieved from http://www.aacnnursing.org/News-Information/Fact-Sheets/Enhancing-Diversity

American Nurses Association (2015a), *Scope and standards of practice, 3rd edition*. Sliver Spring, MD: ANA.

American Nurses Association (ANA). (2015b) Code of ethics for nurses with interpretive statements. Silver Springs, MD: Nursesbooks.org.

Anthony, E., Lionel, R., Hillel, R., Sulin, S., Andreas, S., (2018). The Effects of Immigration in Developed Countries: Insights from Recent Economic Research. *CEPII Research Center. https://ideas.repec.org/p/cii/cepipb/2018-22.html*

Ardalan, F., Bagheri-Saweh, M.-I., Etemadi-Sanandaji, M., Nouri, B., & Valiee, S. (2018). Barriers of nurse-patient communication from the nurses' point of view in educational hospitals affiliated to Kurdistan University of Medical Sciences. *Nursing Practice Today, 5*(3), 326–334.

Attum, B., Waheed, A., & Shamoon, Z. (2018). Cultural competence in the care of Muslim patients and their families. Available from: https://www-ncbi-nlm-nih-gov.

Betancourt, J. R., Green, A. R., & Carrillo, J. E. (2002). *Cultural competence in health care: Emerging frameworks and practical approaches* (Vol. 576). New York, NY: Commonwealth Fund, Quality of Care for Underserved Populations.

Blaikie, N. W. H., & Priest, J. (2019). *Designing social research: the logic of anticipation*. Medford, Ma Polity Press.

Blanck, P., & Martinis, J. G. (2015). "The right to make choices": The national resource center for supported decision-making. *Inclusion, 3*(1), 24-33.

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. Sage.

Budiman, A. (2020, August 20). Key findings about U.S. immigrants. Pew Research Center; Pew Research Center. https://www.pewresearch.org/fact-tank/2020/08/20/key-findings-about-u-s-immigrants/

Campinha-Bacote, J. (2002). Process of cultural competence in the delivery of healthcare services: A model of care. *Journal of Transcultural Nursing, 13*(3), 181–184. https://doi-org.libproxy.uncg.edu/10.1177/1045960201300

Červený, M., Dimunová, L., Della Pelle, C., Papp, K., Siaki, L. L. A., Kilíková, M., & Nagórska, M. (2020). Self-Reported Cultural Competence of Nurses Providing Nursing Care in Slovakia. *Journal of Nursing Scholarship, 52*(6), 705-712.

Chang, H.-Y., Yang, Y.-M., & Kuo, Y.-L. (2013). Cultural Sensitivity and Related Factors Among Community Health Nurses. *Journal of Nursing Research, 21*(1), 67–73. https://doi.org/10.1097/jnr.0b013e3182829cb9

Charmaz, K., & Belgrave, L. (2012). Qualitative interviewing and grounded theory analysis. *The SAGE handbook of interview research: The complexity of the craft*, *2*, 347-365.

Chen, C.-I., & Huang, M.-C. (2018). Exploring the growth trajectory of cultural competence in Taiwanese paediatric nurses. *Journal of Clinical Nursing, 27*(23–24), 4331–4339. https://doi.org/10.1111/jocn.14526

Cicolini, G., Della Pelle, C., Comparcini, D., Tomietto, M., Cerratti, F., Schim, S. M., Di Giovanni, P., & Simonetti, V. (2015). Cultural Competence Among Italian Nurses: A Multicentric Survey. *Journal of Nursing Scholarship, 47*(6), 536–543. https://doi.org/10.1111/jnu.12165

Cioffi, J. (2005). Nurses' experiences of caring for culturally diverse patients in an acute care setting. *Contemporary Nurse, 20*(1), 78–86. https://doi.org/10.5172/conu.20.1.78

Clayton, J., Isaacs, A. N., & Ellender, I. (2016). Perioperative nurses' experiences of communication in a multicultural operating theatre: A qualitative study. International *Journal of Nursing Studies, 54*, 7–15. https://doi.org/10.1016/j.ijnurstu.2014.02.014

Cooper, H. M. (1998). *Synthesizing research: A guide for literature reviews* (3rd ed.). Thousand Oaks: CA: Sage.

Creswell, J. W., & Clark, V. L. P. (2017). *Designing and conducting mixed methods research*. Sage publications.

Creswell, J. W., & Creswell, J. D. (2017). *Research design: Qualitative, quantitative, and mixed methods approaches*. Sage publications.

Culture matters: using a cultural contexts of health approach to enhance policymaking. (2017). Www.euro.who.int. Retrieved January 26, 2021, from https://www.euro.who.int/en/health-topics/health-determinants/behavioural-and-cultural-insights-forhealth/publications/2017/culture-matters-using-a-cultural-contexts-of-health-approach-to-enhance-policy-making-2017

Debesay, J., Harsløf, I., Rechel, B., & Vike, H. (2014). Facing diversity under institutional constraints: challenging situations for community nurses when providing care to ethnic minority patients. *Journal of Advanced Nursing, 70*(9), 2107–2116. https://doi.org/10.1111/jan.12369

Debesay, J., Harsløf, I., Rechel, B., & Vike, H. (2014). Facing diversity under institutional constraints: challenging situations for community nurses when providing care to ethnic minority patients. *Journal of Advanced Nursing, 70*(9), 2107–2116. https://doi.org/10.1111/jan.12369

Del Pino, F. J. P., Soriano, E., & Higginbottom, G. M. (2013). Sociocultural and linguistic boundaries influencing intercultural communication between nurses and Moroccan patients in southern Spain: a focused ethnography. *BMC nursing, 12*(1), 14.

Delgado, D. A., Ness, S., Ferguson, K., Engstrom, P. L., Gannon, T. M., & Gillett, C. (2013). Cultural competence training for clinical staff: Measuring the effect of a one-hour class on cultural competence. *Journal of Transcultural Nursing, 24*(2), 204-213.

Derose, K. P., Escarce, J. J., & Lurie, N. (2017). Immigrants and Health Care: Sources of Vulnerability. *Health Affairs, 26*(5), 1258–1268. https://doi.org/10.1377/hlthaff.26.5.1258

Dicicco-Bloom, B., & Crabtree, B. (2006). The qualitative research interview. *Medical Education*, *40*(4), 314–321

Diversity Makes America Great: We Are a Nation of Immigrants - InterAction. (2018). InterAction. https://www.interaction.org/blog/diversity-makes-america-great-we-are-a-nation-of-immigrants/

Durham, K., & Pollard, D. (2010). Experiences of certified nurse midwives in providing culturally competent care for Hispanic women. *Southern Online Journal of Nursing Research*, *10*(1), 1–14.

Eklöf, N., Hupli, M., & Leino-Kilpi, H. (2014). Nurses' perceptions of working with immigrant patients and interpreters in Finland. *Public Health Nursing, 32*(2), 143–150. https://doi.org/10.1111/phn.12120

Firoozi, F., Mozaffari, N., Iranpour, S., Molaei, B., & Shamshiri, M. (2020). The status of cultural care among nurses working in different wards of teaching hospitals in Ardabil, Iran: A cross-sectional survey study. *International Journal of Care Coordination, 23*(2-3), 115-122.

Fisher, T. L., Burnet, D. L., Huang, E. S., Chin, M. H., & Cagney, K. A. (2007). Cultural leverage: Interventions using culture to narrow racial disparities in health care. *Medical Care Research and Review, 64*(5), 243s–282s. https://doi-org.libproxy.uncg.edu/10.1177/10775587073054

Forscher, P. S., Lai, C. K., Axt, J. R., Ebersole, C. R., Herman, M., Devine, P. G., & Nosek, B. A. (2019). A meta-analysis of procedures to change implicit measures. *Journal of Personality and Social Psychology, 117*(3), 522.

Frazee, S. (2018). Transcultural Nursing Strategies that Promote Culturally Congruent Care by Empowering Charge Nurses as Leaders...2018 ANNA National Symposium, Las Vegas, NV. April 15-18, 2018. *Nephrology Nursing Journal*, *45*(2), 197. https://doiorg.libproxy.uncg.edu/10.1016/j.cnur.2010.10.002

Gallagher, A. T. (2018). The Global Compact for Migration: What Happened? And What's Next? *Thomson Reuters Foundation News,* 11 December. Available at http://news.trust.org/item/20181211095245-

Garneau, A., & Pepin, J. (2015). A constructivist theoretical proposition of cultural competence development in nursing. *Nurse Education Today, 35*(11), 1062–1068. https://doi.org/10.1016/j.nedt.2015.05.019

Goffman, E. (1959). *The presentation of self in everyday life*. New York, NY: Penguin Press.

Goodman, P., Edge, B., Agazio, J., & Prue-Owens, K. (2015). Cultural awareness: Nursing care of Iraqi patients. *Journal of Transcultural Nursing*, *26*(4), 395-401.

Graham, A., Gilchrist, K. L., & Rector, C. (2011). The lived experiences of OB nurses communicating with non–English speaking OB clients with and without an interpreter. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 40*, S116-S117.

Halligan, P. (2006). Caring for patients of Islamic denomination: critical care nurses' experiences in Saudi Arabia. *Journal of clinical nursing*, *15*(12), 1565-1573.

Hart, P. L., & Mareno, N. (2014). Cultural challenges and barriers through the voices of nurses. *Journal of clinical nursing*, *23*(15-16), 2223-2233.

Heitzler, E. T. (2017). Cultural Competence of Obstetric and Neonatal Nurses. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 46*(3), 423–433. https://doi.org/10.1016/j.jogn.2016.11.015

Hetland, B., McAndrew, N., Perazzo, J., & Hickman, R. (2018). A qualitative study of factors that influence active family involvement with patient care in the ICU: Survey of critical care nurses. *Intensive and Critical Care Nursing, 44*, 67-75.

Holy Quran 20:55

Horrigan-Kelly, M., Millar, M., & Dowling, M. (2016). Understanding the key tenets of Heidegger's philosophy for interpretive phenomenological research. *International Journal of Qualitative Methods*, *15*(1), 1609406916680634.

Høye, S., & Severinsson, E. (2008). Intensive care nurses' encounters with multicultural families in Norway: An exploratory study. *Intensive and Critical Care Nursing, 24*(6), 338–348. https://doi.org/10.1016/j.iccn.2008.03.007

Husserl, E. (1960). *Cartesian meditations: An introduction to phenomenology* (D. Cairns, Trans.). The Hague: Martinus Nijhoff

Husserl, E. (1967). *Ideas: General introduction to pure phenomenology* (W. R. Boyce Gibson, Trans.). George Allen & Unwin

Ian, C., Nakamura-Florez, E., & Lee, Y.-M. (2016). Registered nurses' experiences with caring for non-English speaking patients. *Applied Nursing Research, 30,* 257–260. https://doi.org/10.1016/j.apnr.2015.11.009

Immigrants in the United States. (August 6, 2020). American Immigration Council. Retrieved from https://www.americanimmigrationcouncil.org/research/immigrants-in-the-united-states

International Migration 2019 Highlights. (n.d.). Retrieved January 26, 2021, from https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/undesa_pd_2020_internat

Ismail, S., & Hatthakit, U. (2018). Islam-Based Caring for the Harmony of Life among Moslem Critically Ill Patients. *Evidence Based Care, 8*(2), 28-38.

James, N., & Busher, H. (2006). Credibility, authenticity and voice: Dilemmas in online interviewing. *Qualitative research*, *6*(3), 403-420.

Jane Cioffi, R. N. (2003). Communicating with culturally and linguistically diverse patients in an acute care setting: nurses' experiences. *International Journal of Nursing Studies, 40*(3), 299–306. https://doi.org/10.1016/s0020-7489(02)00089-5

Johansson, L., Golsäter, M., & Hedberg, B. (2016). Health dialogue with non-native-speaking parents: Child health nurses' experiences. *Nordic Journal of Nursing Research, 36*(4), 209–215. https://doi.org/10.1177/2057158516635480

Johnstone, M.-J., Hutchinson, A. M., Redley, B., & Rawson, H. (2016). Nursing Roles and Strategies in End-of-Life Decision Making Concerning Elderly Immigrants Admitted to Acute Care Hospitals. *Journal of Transcultural Nursing, 27*(5), 471–479. https://doi.org/10.1177/1043659615582088

Jones, S. M. (2008). Emergency Nurses' Caring Experiences with Mexican American Patients. *Journal of Emergency Nursing, 34*(3), 199–204. https://doi.org/10.1016/j.jen.2007.05.009

Kallio, H., Pietilä, A., Johnson, M., & Kangasniemi, M. (2016). Systematic methodological review: Developing a framework for a qualitative semi-structured interview guide. *Journal of Advanced Nursing, 72*(12), 2954–2965. https://doi.org/10.1111/jan.13031

Käufer, S., & Chemero, A. (2015). *Phenomenology: An introduction*. John Wiley & Sons.

Kim, H., Sefcik, J. S., & Bradway, C. (2017). Characteristics of qualitative descriptive studies: A systematic review. *Research in Nursing & Health*, *40*(1), 23–42.

Kuwano, N., Fukuda, H., & Murashima, S. (2016). Factors Affecting Professional Autonomy of Japanese Nurses Caring for Culturally and Linguistically Diverse Patients in a Hospital Setting in Japan. *Journal of Transcultural Nursing, 27*(6), 567–573. https://doi.org/10.1177/1043659615587588

Lai, W. F. trans. (2000). *Ethnography: Step by step.* (Fetterman, D. M.). Taipei City, Taiwan: Hurng-Chih Book Co. (Original work published 1998)

Leininger, M. (1997). Overview of the theory of culture care with the ethnonursing research method. *Journal of Transcultural Nursing, 8*(2), 32–52. doi:10.1177/104365969700800205

Leininger, M. M. (1978). Leininger's conceptual and theory-generating model to study transcultural and ethnonursingethnocaring constructs. In M. M. Leininger (Ed.), *Transcultural nursing: Concepts, theories, and practice* (p. 39). New York, NY: Wiley.

Leininger, M. M. (1995b). *Transcultural nursing: Concepts, theories, and practice* (2nd ed.). Columbus, OH: McGraw-Hill.

Leininger, M. M. (2001). *Culture care diversity and universality: A theory of nursing*. Sudbury, MA: Jones & Bartlett.

Leininger, M. M. (2002a). Part I: The theory of culture care diversity and universality and the ethnonursing method. In Leininger, M. M., McFarland, M. R. (Eds.), *Transcultural nursing: Concepts, theories, research, and practice* (3rd ed., pp. 71-98). New York, NY: McGraw-Hill.

Leininger, M. M. (2002b). The future of transcultural nursing: A global perspective. In Leininger, M. M., McFarland, M. R. (Eds.), *Transcultural nursing: Concepts, theories, research, and practice* (3rd ed., pp. 577–595). McGraw-Hill.

Leininger, M. M. (2002c). Part I: Toward integrative generic and professional health care. In Leininger, M. M., McFarland, M. R. (Eds.), *Transcultural nursing: Concepts, theories, research, and practice* (3rd ed., pp. 145-156). New York, NY: McGraw-Hill

Leininger, M. M. (2002d). Transcultural nursing administration and consultation. In Leininger, M. M., McFarland, M. R. (Eds.), *Transcultural nursing: Concepts, theories, research, and practice* (3rd ed., pp. 563-573). New York, NY: McGraw-Hill.

Leininger, M. M. (2006a). Culture care diversity and universality theory and evolution of the ethnonursing method. In Leininger, M. M., McFarland, M. R. (Eds.), *Culture care diversity and universality: A worldwide nursing theory* (2nd ed., pp. 1-41). Sudbury, MA: Jones & Bartlett.

Leininger, M. M. (2006b). Culture care theory and uses in nursing administration. In Leininger, M. M., McFarland, M. R. (Eds.), *Culture care diversity and universality: A worldwide nursing theory* (2nd ed., pp. 365-379). Sudbury, MA: Jones & Bartlett.

Leininger, M. M. (2015). Leininger's father protective care. In McFarland, M. R., Wehbe-Alamah, H. B. (Eds.), *Leininger's culture care diversity and universality: A worldwide nursing theory* (3rd ed., pp. 119-136). Burlington, MA: Jones & Bartlett Learning.

Leininger, M. M. (Ed.). (1991a). *Culture care diversity and universality: A theory of nursing.* New York, NY: National League for Nursing Press.

Leininger, M. M. (Ed.). (1991b). The theory of culture care diversity and universality. In Leininger, M. M. (Ed.), *Culture care diversity and universality: A theory of nursing* (pp. 5-68). New York, NY: National League for Nursing Press.

Lemon, N. and Taylor, H. (1997) *Caring in casualty: the phenomenology of nursing care*. In: Hayes,

LicSc, S. K. (2018). Nurses' experiences caring for immigrant patients in psychiatric units. *International Journal of Caring Sciences, 11*(3), 1802-1811.

Lin, C.-N., Mastel-Smith, B., Alfred, D., & Lin, Y.-H. (2015). Cultural Competence and Related Factors Among Taiwanese Nurses. *Journal of Nursing Research, 1*. https://doi.org/10.1097/jnr.0000000000000097

Lin, M. H., Chang, T. H., Lee, Y. H., Wang, P. Y., Lin, L. H., & Hsu, H. C. (2019). Developing and validating the Nursing Cultural Competence Scale in Taiwan. *PloS one*, *14*(8), e0220944.

Lin, M.-H., Wu, C.-Y., & Hsu, H.-C. (2019). Exploring the experiences of cultural competence among clinical nurses in Taiwan. *Applied Nursing Research, 45*, 6–11. https://doi.org/10.1016/j.apnr.2018.11.001

Lipka, M. (2017, August 9). *Muslims and Islam: Key findings in the U.S. and around the world*. Pew Research Center; Pew Research Center. https://www.pewresearch.org/fact-tank/2017/08/09/muslims-and-islam-key-findings-in-the-u-s-and-around-the-world/

Listerfelt, S., Fridh, I., & Lindahl, B. (2019). Facing the unfamiliar: Nurses' transcultural care in intensive care – A focus group study. *Intensive and Critical Care Nursing, 55*, 102752. https://doi.org/10.1016/j.iccn.2019.08.002

Mackie, B. R., Marshall, A. P., & Mitchell, M. L. (2021). Exploring family participation in patient care on acute care wards: A mixed-methods study. *International Journal of Nursing Practice, 27*(2), e12881.

Manley, K., Jackson, C., & McKenzie, C. (2019). Microsystems culture change: A refined theory for developing person-centered, safe, and effective workplaces based on strategies to embed a safety culture. *International Practice Development Journal, 9*(2).

Marion, L., Douglas, M., Lavin, M., Barr, N., Gazaway, S., Thomas, L., Bickford, C., (November 18, 2016) "Implementing the New ANA Standard 8: Culturally Congruent Practice" OJIN: The Online Journal of Issues in Nursing Vol. 22 No. 1.

Markey, K., Tilki, M., & Taylor, G. (2017). Understanding nurses' concerns when caring for patients from diverse cultural and ethnic backgrounds. *Journal of Clinical Nursing, 27*(1–2), e259–e268. https://doi.org/10.1111/jocn.13926

Masci, D. (2015, April 15). *Europe projected to retain its Christian majority, but religious minorities will grow*. Pew Research Center; Pew Research Center. https://www.pewresearch.org/fact-tank/2015/04/15/europe-projected-to-retain-its-christian-majority-but-religious-minorities-will-grow/

Matua, G. A., & Van Der Wal, D. M. (2015). Differentiating between descriptive and interpretive phenomenological research approaches. *Nurse researcher*, *22*(6).

Mboane, R., & Bhatta, M. P. (2015). Influence of a husband's healthcare decision making role on a woman's intention to use contraceptives among Mozambican women. *Reproductive Health, 12*(1), 1–8. https://doi-org.libproxy.uncg.edu/10.1186/s12978-015-0010-2

McCormack, B., & McCance, T. (2017). Underpinning principles of person-centered practice. In B. McCormack & T. McCance (Eds.), *Person-centered practice in nursing and healthcare: Theory and practice* (pp. 13–35). Wiley Blackwell.

Meho, L. I. (2006). E-mail interviewing in qualitative research: A methodological discussion. *Journal of the American society for information science and technology*, *57*(10), 1284-1295.

Morrow, R., Rodriguez, A., & King, N. (2015). Colaizzi's descriptive phenomenological method. *The psychologist*, *28*(8), 643-644.

Morse, J. and Field, P. (1995) *Qualitative research methods for health professionals*. Thousand Oaks, CA: Sage

Mujallad, A. (2016). Modesty Among Muslim Women: Implications for Nursing Care. *Medsurg nursing, 25*(3).

Murcia, S. E. A., & Lopez, L. (2016). The experience of nurses in care for culturally diverse families: A qualitative meta-synthesis. *Revista Latino-Americana de Enfermagem, 24*(0). https://doi.org/10.1590/1518-8345.1052.2718

Muslim Population by State 2020. (n.d.). Worldpopulationreview.com. https://worldpopulationreview.com/state-rankings/muslim-population-by-state

O'Neill, C. S., Yaqoob, M., Faraj, S., & O'Neill, C. L. (2017). Nurses' care practices at the end of life in intensive care units in Bahrain. *Nursing Ethics, 24*(8), 950-961.

Odeh 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*(3), 284-291.

Pew Research Center. (2016, December 8). *2. Discrimination and conflicts in U.S. society*. Pew Research Center. https://www.pewresearch.org/politics/2016/12/08/2-discrimination-and-conflicts-in-u-s-society/

Pew Research Center. (2018). *New estimates show U.S. Muslim population continues to grow*. Retrieved from https://www.pewresearch.org/fact-tank/2018/01/03/new-estimates-show-u-s-muslim-population-continues-to-grow/

Phillips-Pula, L., Strunk, J., & Pickler, R. H. (2011). Understanding phenomenological approaches to data analysis. *Journal of Pediatric Health Care*, *25*(1), 67–71. https://doi.org/10.1016/j.pedhc.2010.09.004

Polit, D. F., & Beck, C. T. (2014). *Essentials of Nursing Research: Appraising Evidence for Nursing Practice* (8th ed.). United States: Philadelphia: Wolters Kluwer Health.

Rassool, G. H. (2015). Cultural competence in nursing Muslim patients. *Nursing Times*, *111*(14), 12–15.

Rifai, E., Janlöv, A.-C., & Garmy, P. (2018). Public health nurses' experiences of using interpreters when meeting with Arabic-speaking first-time mothers. *Public Health Nursing, 35*(6), 574–580. https://doi.org/10.1111/phn.12539

Rosendahl, S. P., Söderman, M., & Mazaheri, M. (2016). Immigrants with dementia in Swedish residential care: an exploratory study of the experiences of their family members and Nursing staff. *BMC Geriatrics, 16*(1). https://doi.org/10.1186/s12877-016-0200-y

Salman, K., & Zoucha, R. (2010). Considering faith within culture when caring for the terminally ill Muslim patient and family. *Journal of Hospice & Palliative Nursing*, *12*(3), 156–163.

Schroyen, S., Missotten, P., Jerusalem, G., Gilles, C., & Adam, S. (2016). Ageism and caring attitudes among nurses in oncology. *International Psychogeriatrics*, *28*(5), 749–757.

Sevinç, S. (2017). Nurses' Experiences in a Turkish Internal Medicine Clinic with Syrian Refugees. *Journal of Transcultural Nursing*, *29*(3), 258–264. https://doi.org/10.1177/1043659617711502

Sharifi, S., Valiee, S., Nouri, B., & Vatandost, S. Investigating patients, attitudes toward receiving care from an opposite-gender nurse. *Nursing Forum*, *56*(2), 322–329.

Sidumo, E. M., Ehlers, V. J., & Hattingh, S. P. (2010). Cultural knowledge of non-Muslim nurses working in Saudi Arabian obstetric units. *Curationis, 33*(3), 48-55.

Singer, E., & Couper, M. P. (2017). Some methodological uses of responses to open questions and other verbatim comments in quantitative surveys. Methods, data, analyses: *a journal for quantitative methods and survey methodology (mda), 11*(2), 115-134.

Skoog, M., Hallström, I., & Berggren, V. (2017). 'There's something in their eyes' - Child Health Services nurses' experiences of identifying signs of postpartum depression in non-

Swedish-speaking immigrant mothers. *Scandinavian Journal of Caring Sciences, 31*(4), 739–747. https://doi.org/10.1111/scs.12392

Smith, J., Flowers, P. Larkin, M. (2009) *Interpretative phenomenological analysis*: theory, method and research. Los Angeles, CA: Sage

Söderman, M., & Rosendahl, S. P. (2016). Caring for Ethnic Older People Living with Dementia – Experiences of Nursing *Staff. Journal of Cross-Cultural Gerontology, 31*(3), 311–326. https://doi.org/10.1007/s10823-016-9293-1

Suk, M. H., Oh, W.-O., & Im, Y. (2018). Factors affecting the cultural competence of visiting nurses for rural multicultural family support in South Korea. *BMC Nursing, 17*(1). https://doi.org/10.1186/s12912-017-0269-4

Tassone, B. G. (2017). The relevance of Husserl's phenomenological exploration of interiority to contemporary epistemology. Palgrave Communications, 3(1), 1-11.

The Changing Global Religious Landscape. (2017, April 5). Pew Research Center's Religion & Public Life Project; Pew Research Center's Religion & Public Life Project. https://www.pewforum.org/2017/04/05/the-changing-global-religious-landscape/#global-population-projections-2015-to-2060

The Integration of Immigrants into American Society. (2015). The National Academic Press. Retrieved February 1, 2021, from https://www.nap.edu/read/21746/chapter/8

Tufford, L., & Newman, P. (2012). Bracketing in qualitative research. *Qualitative social work*, *11*(1), 80-96.

U.S. Census Bureau (2021). 2020 Census Statistics Highlight Local Population Changes, and Nationals Racial and Ethnic Diversity. Released August 12, 2021. Available at: https://www.census.gov/newsroom/press-releases/2021/population-changes-nations-diversity.html

United Nations Population Division | Department of Economic and Social Affairs. (2019). Un.org. https://www.un.org/en/development/desa/population/publications/database/index.asp

Van Manen, M. (1997) Researching lived experience: human science for an action sensitive pedagogy. 2nd ed. London, ON: Althouse

Van Rooyen, D., Telford-Smith, C. D., & Strümpher, J. (2010). Nursing in Saudi Arabia: Reflections on the experiences of South African nurses. *Health SA Gesondheid, 15*(1).

Vasileiou, K., Barnett, J., Thorpe, S., & Young, T. (2018). Characterizing and justifying sample size sufficiency in interview-based studies: systematic analysis of qualitative health research over a 15-year period. *BMC medical research methodology*, *18*(1), 1-18.

Vatandost, S., Cheraghi, F., & Oshvandi, K. (2020). Facilitators of professional communication between nurse and opposite gender patient: a content analysis. *Maedica, 15*(1), 45.

Vespa, J., Armstrong, D. M., & Medina, L. (2018). *Demographic turning points for the United States: Population projections for 2020 to 2060.* Washington, DC: US Department of Commerce, Economics and Statistics Administration, US Census Bureau. P25-1144, U.S. Census Bureau, Washington, DC, 2020.

Von Herrmann, F. W. (2013). *Hermeneutics and reflection: Heidegger and Husserl on the concept of phenomenology*. University of Toronto Press.

Vydelingum, V. (2006). Nurses' experiences of caring for South Asian minority ethnic patients in a general hospital in England. Nursing Inquiry, 13(1), 23-32.

Waller, T., Lampman, C., & Lupfer-Johnson, G. (2012). Assessing bias against overweight individuals among nursing and psychology students: an implicit association test. *Journal of Clinical Nursing, 21*(23-24), 3504-3512.

Watts, K. J., Meiser, B., Zilliacus, E., Kaur, R., Taouk, M., Girgis, A., Butow, P., Goldstein, D., Hale, S., Perry, A., Aranda, S. K., & Kissane, D. W. (2017). Communicating with patients from minority backgrounds: Individual challenges experienced by oncology health professionals. *European Journal of Oncology Nursing, 26*, 83–90. https://doi.org/10.1016/j.ejon.2016.12.001

Wilkes, R., & Wu, C. (2019). Immigration, Discrimination, and Trust: A Simply Complex Relationship. *Frontiers in Sociology, 4*. https://doi.org/10.3389/fsoc.2019.00032

Wong, A. K.-S., Ong, S. F., Matchar, D. B., Lie, D., Ng, R., Yoon, K. E., & Wong, C. H. (2017). Complexities and Challenges of Singapore Nurses Providing Post-Acute Home Care in Multicultural Communities: A Grounded Theory Study. *Journal of Transcultural Nursing, 29*(5), 402–409. https://doi.org/10.1177/1043659617736884

World Health Organization. (2010). Health of migrants: the way forward: report of a global consultation, Madrid, Spain, 3-5 March 2010.

World Health Organization. (2018). *Health inequities and their causes* .Retrieved from. https://www.who.int/news-room/facts-in-pictures/detail/health-inequities-and-their-causes

Wright-St Clair, V. (2015). Doing (interpretive) phenomenology. *Qualitative research methodologies for occupational science and therapy*, 53-69.

Yilmaz, M., Toksoy, S., Direk, Z. D., Bezirgan, S., & Boylu, M. (2017). Cultural Sensitivity Among Clinical Nurses: A Descriptive Study. *Journal of Nursing Scholarship, 49*(2), 153–161. https://doi.org/10.1111/jnu.12276

Zeilani, R., & Seymour, J. E. (2012). Muslim women's narratives about bodily change and care during critical illness: A qualitative study. *Journal of Nursing Scholarship, 44*(1), 99-107.

Zimmermann, K. A. (2017, July 13). What Is Culture? | Definition of Culture. Live Science; Live Science. https://www.livescience.com/21478-what-is-culture-definition-of-culture.html

APPENDIX A: INFORMATION SHEET

UNIVERSITY OF NORTH CAROLINA AT GREENSBORO
SCHOOL OF NURSING

INFORMATION SHEET

TITLE: Hospital Nurses' Experiences of Providing Care for Muslim Patients in the United States

STUDENT PI: Zanaib Alfar, MSN RN, PhD student

FACULTY ADVISOR: Dr. Susan Letvak

Are you a Registered Nurse who has cared for a Muslim patient in the hospital? Would you be willing to be interviewed virtually about this experience?

Hello, my name is Zainab Alfar. I'm a PhD in Nursing student from the University of North Carolina at Greensboro and I am conducting a research study to explore nurses' experiences of providing care for Muslim patients in the USA.

Your participation is completely voluntary, you have the right to not complete the interview at any time. You will be interviewed once and will be asked to answer several questions. The interview will be conducted virtually and will last 45 to 60 minutes. I will audio-record the interview to be sure I can fully capture your words. You will not have to answer any question that you do not want to answer. You may withdraw your consent to participate at any time, without penalty.

Research studies are designed to obtain new knowledge which may help nurses in the future with providing care to members of a different culture however, there is no direct benefit for you participating in this study. The only risks of participating are you may be embarrassed answering some of the questions and I will know your identity. However, all measures will be taken to avoid embarrassment. You may take a short break and You may stop the interview.

Once the interview is transcribed the tape will immediately be erased and no identifying information about you will be retained. I will transcribe the interview myself in a private area wearing headphones so nobody else will hear your voice. All transcripts will only be identified by number and the data will be stored on my personal password protected computer with a firewall and in UNCG BOX which is highly secure server.

Information obtained will not be shared with your organization. While I may use direct quotes from you in the study findings, they will be quoted as "a nurse said…" All information obtained

in this study is strictly confidential unless disclosure is required by law. There are no costs to you, or payments made for participating in this study, however, as a small token of appreciation you will receive a $25 gift card.

You may contact Zainab Alfar at 336-455-6238 or zaalfar@uncg.edu with questions about the research study. This study is being directed by Dr. Susan Letvak at UNC Greensboro School of Nursing (saletvak@uncg.edu). As a research subject, you may contact the Institutional Review Board at 336-256-0253 if you have questions or concerns about your rights.

APPENDIX B: INTERVIEW GUIDE

Interview Guide

1. Share with me an experience you have had with caring for a Muslim patient.
2. Have you faced any difficulties while you were caring for Muslim patients?
   - Have you noticed any different expectations from Muslim patients?
3. What is your knowledge about Islamic principles and culture?
   - How does the hospital or nursing administration provide you with sufficient knowledge about Muslim patients?
   - What kind of training does the hospital or nursing administration provide to familiarize you with Muslim patients? An alternative question…
   - Have you attended any workshops or lectures about caring for Muslim patients?
   - Have you done any independent research on the topic? (e.g. Internet).
4. Have you ever asked Muslim patients about their unique needs based on their religious practices?
   - Have you delayed any procedures because one of your patients wanted to pray?
   - Did you feel that helping your patients to perform these practices was an extra burden on you?
5. How dose culture differences impact your ability to give Muslim patients quality care? (e.g., gender related issues, Modesty, …)
6. How do you evaluate the presence of the family with your Muslim patients?
   - What are the advantages and disadvantages of the kinship and interaction on your patients and on your nursing care?
7. What is your way of communicating with Muslim patients when they can't speak English?
   - How does this impact your nursing care?
8. What are the practices or strategies that your organization/ hospital uses to support you in caring for Multicultural patients?
9. Do you believe that the western healthcare system meets the unique culture needs of Muslim patients?
10. Do you think that any stereotypes about Muslim impact your ability to care for Muslim patients?
11. What else can you share with me that might increase our understanding of what it is like for a non-Muslim nurse to care for a Muslim patient?