Chapter 17
Religio-cultural Considerations When Providing Health Care to American Muslims

Ugo A. Ezenkwele, Gholamreza Sadeghipour Roodsari, and Aasim I. Padela

Introduction

Background

Culture is a set of beliefs, customs, and ways of thinking and, while a potentially separate aspect of one's identity, religion informs culture and impacts the meaning making activities of human behavior. Culture and religion can impact the communication between patients and health care providers, and informs for both parties the meanings attached to illness, preventive health care, and understandings of how illnesses are ameliorated [1–3].

The importance and necessity of cultural awareness in health care delivery has been discussed extensively in the extant health literature [4, 5]. Defined as "the ability of the health care providers to understand and respond to the unique cultural needs brought by patients to the health care encounter" [4], cultural awareness can affect diagnosis and treatment of diseases and may reduce minority health disparities by helping reduce miscommunication and promoting greater understanding and satisfaction within the patient–provider dyad [1, 5, 6]. Cultural awareness leads to cultural competency as a "set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enables them to

U.A. Ezenkwele, M.D., M.P.H. (✉)
Department of Emergency Medicine, Woodhull Medical and Mental Health Center, New York University School of Medicine, Brooklyn, NY, USA
e-mail: Ugo.Ezenkwele@nyumc.org

G.S. Roodsari, M.D., M.P.H.
Emergency Department, King's County Hospital—SUNY Downstate Medical Center, Brooklyn, NY, USA

A.I. Padela, M.D., M.Sc.
Department of Medicine, The University of Chicago, Chicago, IL, USA

M.L. Martin et al. (eds.), *Diversity and Inclusion in Quality Patient Care*,
DOI 10.1007/978-3-319-22840-2_17

work effectively in cross-cultural situations" that engenders delivery of health care responsive to unique cultural needs [5, 7].

Some studies have reported that health care providers may hold the belief that "treating patients equally, regardless of their ethnicity and culture" [8] is sufficient for quality health care delivery. However, this attitude is viewed by some health care experts to reflect a "cultural blindness" [8, 9]. Seeing all patients in the same way may overlook the specific needs of each social, cultural, and religious group and result in a lack of patient-centered care and the perpetuation of health care disparities [5, 7]. Instead, patient centeredness and cultural competence, two different but overlapping concepts, call for addressing the specific cultural needs of each patient and mitigating the disparities resulting from the lack of cultural accommodations [10].

The lack of culturally sensitive care can impair health care delivery in many different ways, the most prominent being poor patient–doctor communication and discriminatory care provision [3, 12]. In the emergency medical setting, effective communication is critically important for several reasons. Emergency departments (EDs) act as a triage center and the initial patient–provider communication may dictate the sorts of clinical care delivered downstream [3]. In critical and highly emergent situations the possibility for misunderstanding to lead to low quality care is high; thus, clear communication that attends to the cultural dimensions of patient's understandings of health and disease is critical for providing quality care [3, 11].

Studies show that racial, ethnic, and religious minority populations receive lower quality care, even with equal insurance status and income [2, 6]. Some of these differences in health outcome relate to poor cross-cultural communication skills on the part of the provider that may lead to mistrust, stereotyping, and discrimination. Culture and religion-based discrimination can appear in two forms: direct discrimination, which includes deliberate unfair treatment of a cultural, ethnic, or religious group, and an indirect form where the health care provider does not appreciate the beliefs and practices of the patient due to ignorance and may not be aware of the patient's specific health care needs because of a lack of cultural awareness [12].

Fortunately, intolerance of stereotyping, cultural competency training, diversification of the health care workforce, and clinical system modifications that are attuned to the religious and cultural sensibilities of patients are effective means for addressing concerns regarding miscommunication and discrimination and may help to reduce health disparities [1, 3, 11].

The Muslim American Population

There are 1.57 billion Muslims in the world comprising 23 % of the total world population [13]. The estimated number of Muslims in the USA varies considerably from 2.5 to 8 million [8, 13–16]. There are many reasons for the wide variance in Muslim population estimates including the lower likelihood of self-reporting

Muslim identity especially in a post-9/11 climate that is at time hostile to Muslim identity and the lack of religious affiliation captured by national census data [16, 17].

In the near future, Islam is expected to be the second largest religion in the USA [8]. A common mistake is to conflate "Arab" ethnicity for "Muslim" identity. The word "Arab" refers to a regional ethnicity or group of individuals tied by a shared language, while the word "Muslim" defines a much larger religious group with common beliefs and values that may not share ethnicity and language [12]. Indeed only 20 % of the Muslims in the world are Arab and in the USA, Arab descendents at highest estimation comprise only 25 % of the total number of Muslims [15, 17, 18].

One fourth of the Muslim American population is African American and another one fourth is from the Middle East and North Africa, including Arabs [18]. Around 25–34 % is from South Asia, mainly including Pakistan, Bangladesh, Indonesia, India, and Malaysia [18]. Muslims, therefore, are a very heterogeneous population, especially in North America, and come from very different cultural, educational, and socioeconomic backgrounds [15]. Despite this and the fact that individuals have different levels of religiosity, Islam plays a central role in daily life of Muslims, they share similar values and ideologies and certain religious beliefs are homogenous [15, 19].

Around 65 % of Muslim population in the USA is foreign born and most of them (94 %) reside in metropolitan areas [17]. Furthermore nearly one-third of Muslim Americans reside in Michigan, California, New York, and Illinois [20].

Discussion

Health Disparities Among Muslim Americans

Studies focusing on health issues of Muslim Americans are limited in number and much of the extant health literature is not empirically based [16, 17]. Nonetheless, the available research confirms that several key Islamic values and concepts impact the health behaviors and hence are important to recognize and acknowledge for the delivery of religio-culturally sensitive health care.

Since 9/11, Muslims are a target of hate and discrimination in the USA and many feel unwelcome in the health care system [7, 17]. For example, Muslim women report being harassed for wearing *hijab* in the health care environment [12, 17]. Muslim immigrants also find the health care system in the USA complicated and confusing. Language barriers, cultural misconceptions and perceptions of disrespect, discrimination, mistrust of the system, lack of knowledge about their religious and cultural practices, fear of poor treatment, and gender preferences in health care are some of the posited reasons leading to health inequities in this population [6–9, 20]. In a recent study, 83 % of health care providers reported challenges while providing care for Muslim women and 94 % of patient participants (Muslim Women) reported that the health care providers did not understand their cultural needs [21].

Islam and Islamic Beliefs

Islam is one of the three Abrahamic religions, along with Christianity and Judaism, and shares many beliefs with these two faiths including the belief in life and judgment after death, one's moral accountability to God and social teachings regarding caring for the indigent [12, 22]. Islam was established in seventh century by Mohammad in Mecca, Saudi Arabia [8, 15]. Shortly after his death, Muslims divided into two main branches: *Sunnis*, which includes the majority (80–90 %) and a *Shiite* minority (10–20 %) who mainly live in Iran, Iraq, and parts of Lebanon [15, 17]. There are two main sources for Islamic morality: the Qur'an, which is considered to be the literal word of God conveyed to the Prophet Mohammad, and the *Sunnah*, which includes the statements, tacit approvals, and actions of the Prophet Mohammad [15, 23]. Of note the Qur'an is also held to be a source of healing and a comfort for the ill, and thus Muslim patients may recite it or have others do so while in the hospital [15, 23].

For some Muslims, the community religious leader, called an *Imam* or *Shaykh*, may provide religious guidance regarding treatment decisions. These leaders can be helpful in encouraging healthy behaviors (e.g., sending messages during religious gatherings) and performing life and death rituals, and are seen as a source of religious guidance for Muslim patients and providers facing moral dilemmas in health care [14, 24].

General Beliefs about Health and the US Health Care System among Muslim Americans

Islam encourages the use of science and medicine [17] and many Muslims respect Western medicine's healing capacity [9, 20, 25]. Physicians are held in high regard with great respect and trust in Muslim communities and therefore, patients tend to submit to their authority without questioning [20, 22]. Qualitative studies have shown that Muslim populations do not consider good health as solely the absence of disease; but rather good health is perceived as a state of balance and poor health as a state of imbalance [25].

There is, in general, the expectation that patients will receive medications: either a prescription to take home or an injection at the hospital. If the health care provider does not prescribe any medicine, the patient may think nothing was done. Therefore, managing expectations or an explanation about the importance of other kinds of treatment or consultation may be required [25].

Prayer

One of the five pillars of Islamic worship is prayer. Muslims are enjoined to pray five times a day at specific intervals starting at dawn and extending into the night with the time of prayer slightly changing daily according to the changes in daylight hours. The

most important prayer of the week occurs on Friday around midday and it is a congregational prayer usually performed in mosques [15]. For prayer, Muslims must stand facing Mecca, the holy city in Saudi Arabia. Therefore, patients may ask about compass directions so that they may face northeast which is the direction towards Mecca in North America [15]. During prayer Muslims observe cycles of standing, bending, and kneeling with the head on the floor [15]. If the patients cannot stand up, they can pray sitting in a chair or bed and prayer should not be interrupted until finished [22]. A quiet environment should be provided for the patient during prayer, if possible [2, 8]. Neutral prayer space has been reported as one of the key health care accommodations asked by Muslim Americans, along with no interruption during the prayer [7].

Before prayer, Muslim patients may request to perform a ritual ablution called *wudu* including washing of the face, hands, arms up to the elbows, and feet [15, 20]. Also important is the general cleanliness of the area. For prayer, one's body, clothes, and place should be free of "dirtiness," including blood, stool, and urine. For this reason, patients usually prefer the bathroom to a bed pan, and use a prayer rug for prayer [2, 8].

Fasting

Fasting during the month of Ramadan is mandatory in Islam. The Islamic calendar is lunar and therefore the time of Ramadan varies and can be in any of the four seasons. As a result, Muslims may face greater challenges when Ramadan occurs during the longer, hotter summer days [15, 22, 26]. During the month, Muslims avoid eating, drinking, and sexual activity from dawn to dusk. Generally, Muslims eat a light meal before dawn and a complete meal after sunset. After sunset, there is usually a family feast and therefore food consumption may paradoxically increase during Ramadan [15, 20].

Although people who are travelling, menstruating women, and sick individuals are exempt from fasting, many Muslims try to fast during illness because not fasting is perceived as a personal failure [15, 20, 22, 26]. We recommend a thorough history to include questions about fasting because it can impact the care being provided, i.e., a diabetic Muslim patient on long-acting insulin will need medication adjustment during a fast [20]. All medications, both oral and injectable, should be adjusted to nighttime administration during Ramadan, when possible. Health care providers should provide positive support and avoid advising patients not to fast if the patient wants to. Muslims may be more likely to take the advice if they believe that their health care provider is knowledgeable about fasting [20, 26]. Involving religious leaders may help in promoting informed choice (both religiously and medically) regarding decisions to fast [26].

Diet

There are specific dietary codes in Islamic law. Not only are pork and alcohol strictly prohibited in Islam, but they are considered "religiously dirty." Therefore, any medicine that is prepared using products derived from swine or alcohol is

forbidden by most religious authorities [19, 20]. Furthermore, meat should only be consumed if it is "*Halal*," meaning the animal is killed in a particular way and specific prayers are recited before slaughtering the animal. *Halal* food is also perceived by some Muslims to be healthier and assists the body to heal [7, 15, 19]. If not available, vegetarian food should be served for Muslim patients who observe these dietary regulations [20].

God's Will and Fatalism

Muslims frequently refer to God in daily conversations. "Praise to God" follows statements with positive connotations, including health. "*In-sha-allah*" (God willing) is used frequently when any plan, wish, or future result is expected; even when making an appointment. These phrases are often a sign of being polite and not being assertive about the future [20]. However, the idea that nothing occurs without the will of God is a major doctrine that may impact health behaviors [14, 22, 23]. Muslims view physicians as the means through which help is received; whereas the healing is endowed by God [14, 22, 23]. Muslim Americans may also view religious leaders (Imam) or family members as adjuncts to healing [14]. The concept of "God's will," however, does not imply that Muslims are fatalistic, but rather that they have a personal responsibility to God to maintain their health and should actively seek help when necessary [20, 25].

Family's Role

The family is a core institution of Muslim society. Decisions about important issues are often made collectively and many family members are often present at the times of birth, illness, and death. Loyalty to one's family and a respect for the elderly are considered important Islamic social teachings [9, 20, 25]. Therefore, a health care provider should build trust with family members, alongside the patient. Complex decision-making may proceed through a family spokesperson—usually the oldest male. Providers should be cognizant of the potential norms regarding surrogate decision-making and familial negotiation [12, 25]. Visiting the sick members of one's community is a communal obligation in Islam and health care providers should expect many people to visit the patient, even if they are not directly related [27].

Death

Death is considered to be a parting from this temporal life towards the eternal one. It is an occasion for many religious rituals [15, 27]. Near the time of death, family members may want to turn the patient's face toward Mecca and to read the Qur'an

to the patient. They may want the patient to say "*shahada*" (testimony of faith) [15, 20, 28]. Brain death and organ donation present complicated ethical challenges and are treated with some ambiguity in Islamic law. Different authorities have endorsed different definitions of death. Some acknowledge brain death as equivalent to death proper in Islam, while others consider only cessation of the heart beat and respiration as death [23, 29]. Similarly some authorities suggest that organ donation is Islamically permissible while others find it problematic. This plurality has its roots in the differences among schools of Islamic law and different moral reasoning methodologies [15, 17, 23]. While some studies have reported that Islamic religiosity might negatively affect the attitude towards organ donation [17, 30, 31], mosque community-based research did not confirm such a relationship [17]. It is even reported that religion can be a motivating factor among Muslims who agree to organ donation [31]. Ethnicity appears to play a role in organ donation attitudes, with Middle Eastern Muslims having the highest rates of belief in cadaveric organ donation, followed by South Asians and African American Muslims [17, 28].

After death, a large group of family members may come to the hospital and participate in the grieving process [20, 28]. Religious rituals performed by family members may include ritual washing and wrapping of the body in a simple white cloth and prompt burial at a Muslim cemetery [27, 28]. Autopsy is another controversial topic. While it is performed on a regular basis in many Muslim countries, it is considered undesired because it is believed that the physical body should be clean, normal appearing, and not distorted to preserve dignity [32, 33].

Gender Roles

In Muslim communities, gender is an important factor of identity and influences social roles. It even affects self-reported health, as women are more likely to self-evaluate their health as poor [34]. Separation of genders is a norm of Muslim societies and depending on acculturation, contact between male and female may be limited to only family members. Skin-to-skin contact, even shaking hands between men and women, is considered inappropriate and is strongly discouraged, although these rules are relaxed somewhat if medical treatment is required. Female patients may also deny physical examinations or delay care if the health care provider is from the opposite gender [8, 15]. Asking for same-gender health care provider is repeatedly the single most frequent cultural accommodation asked by Muslims of both genders [7, 8, 15]. Islamic law dictates a priority-order for physician selection founded upon preserving modesty in cross-gender interaction where Muslim patients are encouraged to seek out Muslim physicians of the same gender, and if not available a non-Muslim from the same gender [35]. Touching the opposite gender, even tapping on their shoulder can make the patient very uncomfortable and be considered offensive [15]. If there is no other choice, having gloves on during a physical exam may help the patient feel more comfortable since it prevents skin to skin contact [2, 35]. Religious teachings also inform dress codes, including covering of the body of both males and particularly females [20, 35]. Therefore, gowns

which adequately cover the patient's body or allowing them to remain dressed in their own clothing is helpful. During the exam, expose only the body part which is being examined, and allow the rest of the body to remain covered [35]. Some women may want to follow the rules of *Hijab*, in which they are instructed to cover the whole body, including the hair, except for face and hands [17, 20, 35].

Sexual relations prior to and outside of marriage are strictly prohibited by Islamic law [9], thus rates of premarital and extramarital sex are quite low in Muslim communities and those relationships bring stigma and shame to the person and the family [8, 20]. It is recommended that sexual history taking be performed with extreme sensitivity (in private and indirectly) and only when necessary [6]. As in all cultures, Islamic gender norms are increasingly variable and as attitudes are evolving, traditional interpretations of gender roles are evolving as well.

Conclusion

Religio-cultural competence is important for delivering high-quality health care. This chapter serves as a basic resource for providing culturally sensitive care to American Muslims. Although Muslim Americans are a population with a common religious identity, significant heterogeneity in religiosity is present within this group. It is important, therefore, to take our guidelines as a general framework for understanding Muslim patient values and health behaviors while being attuned to providing health care accommodations for the specific needs and values of the "Muslim" patient you are treating [9, 20].

Recommendations

- Consider same-gender health care provider and principles of modesty. Avoid opposite gender skin to skin contact. If opposite gender care cannot be avoided, keep the patient covered as much as possible and use a barrier (i.e., gloves).
- Involve family. Discuss severe illness or disease with the elder family member and involve the decision maker member (after patients' consent is obtained).
- Respect and understand the needs for prayer: space, no interruption, cleanliness.
- Meet dietary needs, including Halal meat or vegetarian food, fasting, and adjustments to medication administration.

References

1. Brach C, Fraserirector I. Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. Med Care Res Rev. 2000;57(S1):181–217.
2. Padela A. Can you take care of my mother? Reflections on cultural competency and clinical accommodation. Acad Emerg Med. 2007;14(3):275–7.

3. Richardson LD, Irvin CB, Tamayo-Sarver JH. Racial and ethnic disparities in the clinical practice of emergency medicine. Acad Emerg Med. 2003;10(11):1184–8.
4. American College of Emergency. Cultural awareness and emergency care. Ann Emerg Med. 2008;52(2):189.
5. Betancourt JR, Green AR, Carrillo E, Ananeh-Firempong O. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. Public Health Rep. 2003;118(4):293–302.
6. Ezenkwele UA, Roodsari GS. Cultural competencies in emergency medicine: caring for Muslim-American patients from the Middle East. J Emerg Med. 2013;45(2):168–74.
7. Padela AI, Gunter K, Killawi A, Heisler A. Religious values and healthcare accommodations: voices from the American Muslim community. J Gen Intern Med. 2012;27(6):708–15.
8. Yosef AR. Health beliefs, practice, and priorities for health care of Arab Muslims in the United States: implications for nursing care. J Transcult Nurs. 2008;19(3):284–91.
9. Kulwicki AD, Miller J, Schim SM. Collaborative partnership for culture care: enhancing health services for the Arab community. J Transcult Nurs. 2000;11(1):31–3.
10. Saha S, Beach MC, Cooper L. Patient centeredness, cultural competence and healthcare quality. J Natl Med Assoc. 2008;100(11):1275–85.
11. Padela AI, Punekar I. Emergency medical practice: advancing cultural competence and reducing health care disparities. Acad Emerg Med. 2009;16(1):69–75.
12. Laird LD, Amer MM, Barnett ED, Barnes LL. Muslim patients and health disparities in the UK and the US. Arch Dis Child. 2007;92(10):922–6.
13. Pew Research Center's Forum on Religion & Public Life. Mapping the global Muslim population, a report on the size and distribution of the world's Muslim population, 2009 [cited Nov 1st 2014]. Available from: http://www.pewforum.org/2009/10/07/mapping-the-global-muslim-population/
14. Padela AI, Killawi A, Forman J, DeMonner S, Heisler M. American Muslim perceptions of healing: key agents in healing, and their roles. Qual Health Res. 2012;22(6):846–58.
15. Lawrence P, Rozmus C. Culturally sensitive care of the Muslim patient. J Transcult Nurs. 2001;12(3):228–33.
16. Padela AI, Raza A. Studying healthcare disparities among American Muslims: Mining the MEDLINE literature, using ethnic and nationality markers as a proxy for religious affiliation. J Health Dispar Res Pract. Forthcoming.
17. Inhorn MC, Serour GI. Islam, medicine, and Arab-Muslim refugee health in America after 9/11. Lancet. 2011;378:935–43.
18. Muslim American demographic facts: Allied Media Corporation. Bridges TV- American Muslim Lifestyle Network. 2000. [cited Dec 10th 2014]. Available from: http://www.allied-media.com/AM/
19. Padela AI, Curlin F. Religion and disparities: considering the influences of Islam on the health of American Muslims. J Relig Health. 2012;52(4):1333–45.
20. Hammad A, Kysia R, Rabah R, Hassoun R, Connelly M. Guide to Arab culture: health care delivery to the Arab American community. ACCESS (Arab Community Center for Economic and Social Services), Public Health Education and Research Department; 1999.
21. Hasnain M, Connell KJ, Menon U, Tranmer PA. Patient-centered care for Muslim women: provider and patient perspectives. J Womens Health (Larchmt). 2011;20(1):73–83.
22. Sirois ML, Darby M, Tolle S. Understanding Muslim patients: cross-cultural dental hygiene care. Int J Dent Hyg. 2013;11(2):105–14.
23. Sachedina A. End-of-life: the Islamic view. Lancet. 2005;366:774–9.
24. Padela AI, Killawi A, Heisler M, Demonner S, Fetters MD. The role of Imams in American Muslim health: perspectives of Muslim community leaders in Southeast Michigan. J Relig Health. 2011;50(2):359–73.
25. Basil H, Faisal H. The cultural gap delivering health care services to Arab American population in the United States. J Cult Divers. 2010;17(1):20–3.
26. Kridli SA. Health beliefs and practices of Muslim women during Ramadan. MCN Am J Matern Child Nurs. 2011;36(4):216–21.

27. Sarhill N, LeGrand S, Islambouli R, Davis M, Walsh D. The terminally ill Muslim: death and dying from the Muslim perspective. Am J Hosp Palliat Care. 2001;18(4):251–5.
28. Gatrad R, Sheikh A. Palliative care for Muslims and issues after death. Int J Palliat Nurs. 2002;8(12):594–7.
29. Padela AI, Arozullah A, Moosa E. Brain death in Islamic ethico-legal deliberation: challenges for applied Islamic bioethics. Bioethics. 2013;27(3):132–9.
30. Padela AI, Zaganjor H. Relationships between Islamic religiosity and attitude toward deceased organ donation among American Muslims: a pilot study. Transplantation. 2014;97(12):1292–9.
31. Padela AI, Rasheed S, Warren GJ, Choi H, Mathur AK. Factors associated with positive attitudes toward organ donation in Arab Americans. Clin Transplant. 2011;25(5):800–8.
32. Mohammed M, Kharoshah MA. Autopsy in Islam and current practice in Arab Muslim countries. J Forensic Leg Med. 2014;23:80–3.
33. Rady MY, Verheijde JL. Brain-dead patients are not cadavers: the need to revise the definition of death in Muslim communities. HEC Forum. 2013;25(1):25–45.
34. Asfar T, Ahmad B, Rastam S, Mulloli TP, Ward KD, Maziak W. Self-rated health and its determinants among adults in Syria: a model from the Middle East. BMC Public Health. 2007;7(1):177.
35. Padela AI, Rodriguez del Pozo P. Muslim patients and cross-gender interactions in medicine: an Islamic bioethical perspective. J Med Ethics. 2011;37(1):40–4.