

Arab Muslim Nurses' Experiences Of The Meaning Of Caring

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Abstract

The aim of this study was to understand the meaning of caring as experienced by Arab Muslim nurses within the context of Arab culture. A qualitative approach using ethnographic methodology based on the approaches of Geertz (1973), Fitzgerald (1997) and Davies (1999) was used to develop a description that embeds the phenomena of the nurses' meaning of caring within the cultural context. Good and Good's (1981) meaning-centred approach was used to interpret the nurse's explanatory models of health, illness and healing that inform the caring experience. This study conveys the cultural worlds of Arab Muslim nurses from Saudi Arabia, Lebanon, Jordan and Egypt while caring for Arab Muslim patients in Saudi Arabia. Data were collected over a four year period (2004-2007).

Arab Muslim nurses have a religiously informed explanatory model where health is spiritual, physical and psycho-social well-being. Spirituality is central to the belief system where spiritual needs take priority over physical needs as a distinctive care pattern. The professional health belief system blends into the nurses' cultural and religious belief system, forming a culturally distinct explanatory health beliefs system. This finding suggests that in non-Western health contexts, professional models are not dominant but incorporated into nurses' indigenous worldviews in a way that makes sense within the culture.

Caring is based on shared meanings between nurse and patient. Caring is an act of spirituality and an action by the nurse to facilitate his or her own spirituality and that of the patient. In turn, the nurse receives

reward from Allah for caring actions. A distinct ethical framework based on principles of Islamic bio-ethics guides the nurses in their caring.

This research provides the missing link between Western professional nursing systems and Arab Muslim nurses' caring models and contributes to the development of a caring model that is relevant to, and reflective of, Arab cultural and Islamic religious values. This caring model can provide direction for nurse education and the provision of care to Muslim patients, whether in Arab cultures, Islamic societies or with immigrant Muslim populations. In addition, it provides the basis for an Islamic nursing identity and a beginning point for improving the moral status and image of nursing in the Middle East.

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My supervision team guided me to become a researcher and writer. Dr. Maureen H. Fitzgerald (Primary Supervisor) provided unending support and taught me how to be an ethnographer. In my world, every moment is an ethnographic moment, and Maureen helped to open that world to my eyes, and helped me to interpret and convey the richness of this cultural world to others. She remained committed to my research journey long after official retirement and I am deeply grateful for her dedication.

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Chapter 1: Introduction

Introduction

This thesis conveys the cultural worlds of Arab Muslim¹ nurses caring for Arab Muslim patients in the Middle East. The focus is the nurses' beliefs about health, disease and healing, and how these beliefs translate into their caring experiences within a religious and cultural context.

Discovering the caring experiences of the nurses was a journey that began long before the study documented in this thesis, and will continue after the concluding chapter. This introductory chapter shares how the study began and evolved, provides some background, a statement of purpose and objectives and discusses the significance of this work. The thesis describes the context and direction in the background and methods chapters; a description of the nurses' beliefs and caring experiences in the findings chapters; and further interpretation, discussion and conclusions in subsequent chapters.

Beginning the journey

This ethnographic study grew out of my experience as a nurse executive in large teaching hospitals in Saudi Arabia since 1993. I observed that the biomedical model was imported into the Saudi health system and culture, and people hold health beliefs that may be different to

¹ In this study, the Arab Muslim nurses primarily come from the countries of Saudi Arabia, Jordan, Lebanon and Egypt.

the Western curing disease model (Al-Shahri, 2002). In addition, my earlier research on *Saudi Nurse Leaders: Career Choices and Experiences* (Lovering, 1996) suggested that Saudi nurses have a belief system based on Islamic values that shapes their approach to caring for patients, and that this is different to the Western-derived nursing model. My earlier study noted that Saudi nurses were seeking a professional identity that recognised their Islamic values, Islamic nursing history and Saudi culture as a path to accepting their role as nurses within Saudi society. That study identified a need for a nursing model based on Islamic principles to guide the nurses' practice and to support the development of their Islamic nursing identity (Lovering, 1996).

The idea for the current study occurred during a transcultural nursing conference in 1998 when I listened to research by nurses caring for diverse cultural populations, primarily within a Western health care context. I wrote on my note pad: "What is the meaning of caring for Saudi nurses?" In my nursing practice within the Saudi context, I sensed, but did not understand yet, how their religious and cultural beliefs blended with their professional nurse caring. In designing this study in 2003 I expanded the focus from Saudi nurses to Arab Muslim nurses. This expanded focus was in response to the unsettled situation in Saudi Arabia in 2003 related to fear of terrorism and uncertainty that I could continue to reside in the country until completion of the research; however, I was confident that I would continue working with Arab Muslim nurses in the greater Middle East region. Fortunately, I was able to remain in Saudi Arabia and conducted this research over a four year period (2004 – 2007).

An interest in medical anthropology led me to explore explanatory models (Good & Good, 1981; Kleinman, 1980;), which are beliefs about health, disease and healing and how these beliefs determine health and illness behaviours. I examined the literature on caring in nursing from a theoretical perspective, as well as research on nurses' caring in various cultural contexts. I recognised that in order to understand nurses' care meanings within the cultural context, I needed to first understand their beliefs about health and healing as the basis of their ontology of caring. From the caring literature, I anticipated that the Muslim worldview, Arab cultural beliefs, Islamic nursing history and the professional values of the nursing system would shape the nurses' meaning of caring. The fields of medical anthropology and nursing, in particular caring theory, blended to guide this ethnographic study.

Some background

In nursing, care and caring are defined from a variety of perspectives reflective of the Western Judeo-Christian tradition (Holden & Littlewood, 1991; Narayanasamy & Owens, 2001; Rassool, 2000), with an assumption that nursing has a universal belief system. The view that the role of caring by nurses is culturally constituted is suggested by Holden and Littlewood (1991), Leininger, (1991) and Kyle (1995) and reflected in research conducted within Eastern, Asian and Native American cultures (Chen, 2001; Holroyd, Yue-kuen, Sau-wai, Fung-shan & Wai-wan, 1998; Lundberg & Boonprasabhai, K. 2001; Shin, 2001; Somjee, 1991; Spangler, 1991; Struthers & Littlejohn, 1999; Wong & Pang, 2000; Wong,

Pang, Wang & Zhang, 2003; Yam & Rossiter, 2000). This thesis builds on the view that caring is a cultural construction and attempts to understand ways in which Arab Muslim nurses' beliefs about health, disease and healing are blended into their caring experiences.

A qualitative approach using ethnographic methodology guided the study design. Qualitative research is concerned with the construction of reality to determine the meaning of a phenomenon (Creswell, 1994). Ethnography is concerned with the study of cultures. In an applied setting, ethnography enables the identification of cultural patterns that provide reason and meaning to human values and behaviour (Chambers, 2000). This study blended the complementary interpretive, reflexive ethnographic approaches of Geertz (1973), Fitzgerald (1997) and Davies (1999) to develop description that embeds the phenomena of the nurses' meaning of care in the context of culture. Good and Good's (1981) meaning-centred approach was used to interpret the nurse's explanatory models of health, illness and healing that inform their caring experience.

Purpose and objectives

The purpose of this study was to understand the meaning of caring as experienced by Arab Muslim nurses within the context of Arab culture. Data generation and analysis focused on answering the following questions: 1) What is the explanatory model used by Arab Muslim nurses in the caring experience? 2) What is the meaning of caring as expressed through the narratives of the Arab Muslim nurses?

Significance of study

This study is of value to Arab Muslim and non-Muslim nurses and their patients in Arab cultures. The Arab Muslim nursing community has expressed concerns that their nursing education and practice derives from the Western nursing perspective, which are not always congruent with the cultural and religious beliefs of Arab Muslim nurses or their patients (AbuGharbieh & Suliman, 1992; Al-Darazi, 2003). There have been recent calls for a nursing model based on Arab cultural values and Islamic health beliefs applicable to Muslim nurses and patients in Arab and Islamic societies² (Lovering, 1996; Rassool, 2000). However, limited research has explicated the nursing values and beliefs practiced within this culture. This research provides the missing link between Western professional nursing systems and Arab Muslim nurses' caring models and contributes to the development of a nursing model that is relevant to, and reflective of, Arab cultural and Islamic religious values. The development of such a model can provide direction for nurse education and the provision of care to Muslim patients, whether in Arab cultures, Islamic societies or with immigrant Muslim populations. In addition, it can provide the basis for a nursing identity that is congruent within the Arab culture and a beginning

² In this thesis, Arab refers to the Semitic people of the Middle East region (Arabian Peninsula). Islamic societies are those that have Islam as the dominant religion, such as most countries in the Middle East and other countries such as Indonesia, Pakistan.

point for improving the moral status and image of nursing in the Arab world.

This study adds to transcultural nursing knowledge and contributes to the emerging body of knowledge that there are culturally informed explanatory models and culturally distinct forms of nurses' caring. Insight into the cultural construction of nurses' caring by nurses is of benefit to nurses in all cultural contexts and supports the development of cultural models of care in non-Western nursing contexts.

Overview of thesis

This thesis presents a journey into the cultural world of caring by Arab Muslim nurses. The setting and direction for the journey are conveyed in this introductory chapter and the background and methods chapters. The experience of the journey is conveyed over four findings chapters and with reflection and interpretation flowing in to further chapters on explanatory models and the meaning of caring. The thesis concludes with a reflection on the journey, the significance of the research and future directions.

The setting and direction

The background chapter provides the study context and is divided into three sections: theoretical background, cultural construction of nursing and the context for caring in Middle Eastern nursing. The theoretical background includes the constructionist philosophical stance, a definition of culture, explanatory models and the meaning-centred approach (Good & Good, 1981). In the next section I make the case that

caring is a cultural construction, based on nursing literature on caring and evidence from nursing within Eastern cultures. Further background in the third section gives an overview of the Muslim worldview and explores Islamic nursing history, current issues and research on nurses' experiences of caring in Middle East. This background sets the scene for the research design as described in the chapter on methodology.

Chapter 3 presents the ethnographic approaches that guided this study, those of Geertz (1973), Fitzgerald (1997) and Davies (1999). A description of the Arab Muslim nurses who participated in the study and reflections on my background as the researcher are given. A detailed description of the process of data generation and analysis, including use of conference presentations, nursing ethics discussions, individual and group interviews, immersion in the field experience over a prolonged period (four years) and the extensive reflexive validation process is presented.

Experiencing the nurses' cultural world

The nurses' beliefs about health and healing and their experiences of caring, including ethical and cultural aspects, are conveyed through use of rich and "thick description" (Geertz, 1973) in the findings chapters. The first findings chapter describes the health and illness beliefs of Arab Muslim nurses. These beliefs blend Muslim and Western³ worldviews into

³ In this thesis, the Muslim worldview reflects those values and beliefs that derive from Islam; and are not specifically linked to a geographical region. The Western worldview reflects those values and beliefs reflective of Anglo-Saxon cultures, such as those in Europe, North America and Australasia.

a unique explanatory model that is religiously informed. Health is defined as spiritual, physical and psycho-social well being, and incorporates the concepts of balance and health potential. Spiritual healing methods are used for many forms of disease or illness, including those caused by medical, spiritual or folk beliefs such as the evil eye and *jinn* (spirits). The unique care pattern where spiritual needs may have priority over physical needs is explored.

The Meaning of Caring chapter captures the centrality of spiritual care within the nurses' caring. The historical narrative of Rufaidah as the first nurse in Islam symbolises acceptance of the nurses' caring role within Islam. The beginning point of caring is the relationship between the nurse and God; and nurses' caring actions aim to facilitate the patient's belief in and relationship with God. In turn, the nurse receives reward from God for caring action. The symbolism of the nurses' caring as a spiritual action emerges with the image of nurses being "angels in the air."

Recognition of the ethical dimensions of the nurses' caring was not an intended outcome of this study. However, exploring the religious and cultural ethical aspects of caring added another aspect to understanding caring within this cultural context. The Ethical Dimensions of Caring chapter discusses the Islamic bio-ethical principles that are the basis of ethical approaches in caring by Arab Muslim nurses. Based on available literature and consultation with an Islamic bio-ethics scholar, Western and Islamic bio-ethics approaches are compared. The development of an "ethical decision making approach" for nurses within this cultural context

is described and used to discuss a case study on organ donation in a paediatric intensive care unit

Until this point the thesis has primarily focused on health and illness beliefs within the Muslim worldview, and the way this worldview impacts on the nurses' caring. The last findings chapter focuses on the protection of dignity as a cultural caring action. Cultural and religious values concerning protecting the dignity of patients are presented through various narratives. Regulatory directives, expectations for gender-based caring and gender segregation in the health care encounter highlight the importance of protecting dignity to the nurses and their patients.

Further interpretation and understanding

Chapter 8 discusses the cultural construction of explanatory models and leads into the following chapter on how these beliefs form the basis of nurses' caring. Definitions of health in Western nursing theory and other socio-cultural contexts are explored and an in-depth view of spiritual health in Native American and Eastern nursing and faith-based nursing is compared with the Arab Muslim perspective on health. A key finding is that nurses' explanatory models are cultural constructions from popular, folk and professional sectors and that their professional models are blended into cultural models.

The chapter, *Caring: Shared Meanings and Spirituality*, further explores an important finding of this study, that caring is an act of spirituality based on a meaning system that Arab Muslim nurses share with their patients. A review of the literature on spirituality in nursing and

research on faith-based caring finds similarities and differences in the nature of Arab Muslim nurses' spiritual caring. Through an extensive reflexive validation process, a conceptual drawing (diagram) of the shared spirituality emerged, providing another insight into the fluid nature of shared meanings between Arab Muslim nurses and patients. The reflexive validation process took the findings to a higher theoretical level through development of a diagram illustrating the relationship between the family, caring, Islam, components of caring and values impacting on caring. This diagram of Arab Muslim nurses' caring becomes a starting point for further model development.

The thesis concludes with a description of my research journey and a summary of key findings. It discusses the significance of these findings for Arab and non-Arab Muslim nursing communities, contributions to transcultural nursing knowledge, insights into the cultural construction of caring within non-Western cultural contexts and contributes to emerging knowledge of faith-based nursing. Recommendations for continuing the journey to validate the unique model of caring used by Arab Muslim nurses and development of culturally specific nursing theory are proposed.

Summary

The basic assumptions in this thesis are that nurses' caring is a cultural construction, and that explanatory models are blended with professional forms of caring in culturally specific ways. The inquiry not only serves to answer my question of "what does caring mean for Arab

Muslim nurses,” but can provide the missing link between Western and Arab Muslim nurses’ caring models. This introduction gives an overview to discover the experiences of Arab Muslim nurses’ caring within their cultural world. The reader should now be ready to commence the journey with me as I turn to a more extensive discussion of the theoretical and cultural context of this study.

Chapter 2: Background

Introduction

This chapter provides a description of the setting, or context, for this ethnographic study and explores the state of knowledge and frameworks for interpreting the caring phenomenon within a cultural context using Good and Good's (1981) meaning-centred approach. This background is divided into three sections: theoretical background, the cultural construction of caring and the context of caring in Middle Eastern nursing.

The theoretical background section outlines the philosophical stance and theoretical foundations that guided the study. Perspectives concerning the cultural construction of disease, illness and healing and relationships between explanatory models and the meaning-centred approach (Good & Good, 1981) are discussed. The cultural construction of caring section integrates the literature on caring in nursing with evidence on nurse caring in Eastern societies to make the case that caring in nursing is a cultural construction. The context of caring in Middle Eastern nursing section gives an overview of the Muslim worldview and Arab cultural values, the historical basis of nursing in Islam, current issues in Middle Eastern nursing, and research on nurses' caring in the Middle East.

Theoretical background

A constructionist theoretical perspective guided this study. Constructionist epistemology is concerned with the construction of meaning as interpreted through an interactive process (Crotty, 1998, Davies, 1999). The constructionist ontology asserts that there are multiple, socially constructed realities where reality may be considered the best of competing interpretations (Denzin & Lincoln, 2000; Koch, 1999; Mishler, 1981; Schwandt, 2000). Humans use concepts, models or schemes to make sense of experience within an historical and socio-cultural context. Meanings are constructed against a background of shared understandings, practices and language (Schwandt, 2000, p.197).

Social context is a key issue, as all meaningful reality is socially constructed (Crotty, 1998). Good (1994, p. 176) notes that “all knowledge is culturally located, relative to historical era and perspective.”

Interpretivism is a theoretical perspective within the constructionist paradigm that looks for culturally derived and historically situated interpretations where the goal is to understand meaning rather than truth (Bailey, 1997; Crotty, 1998). There are different historical approaches to interpretivism that have developed within the constructionist paradigm. Common characteristics include seeking to gain meaning and understanding from situations and actions through interpretations and explanations of behaviour rather than seeking cause and effect relationships (Denzin & Lincoln, 2000; Mackenzie, 1994). As explained by Mishler (1981, p. 141), “meaningful reality is constructed through human interpretative activity.”

The purpose of this study was to understand and describe the meaning of caring within a specific cultural and social context. An interpretive perspective was used to construct the meaning of caring within the nurses' explanatory models. The Islamic religion, Islamic health beliefs, the culture of Arab societies, nursing history and professional values provide the social and cultural context from a constructionist view.

A definition of culture

The concept of culture is integral to this study. There are many definitions of culture in anthropology. Definitions may take a materialistic or idealistic perspective (Fitzgerald & Mullahey-O'Byrne, 1996). The materialistic view describes culture as patterns of behaviour or the possessions and symbols of a particular group. In the idealistic definition, culture is described as a group's ideas, beliefs and values (Armstrong & Fitzgerald, 1996).

Some definitions link the materialistic and idealistic perspective, such as Hahn's (1995, p. 66) definition of culture, as "a coherent set of values, concepts, beliefs, and rules that guide and rationalise people's behaviour in society." Ember, Ember and Peregrine (2002, p. 217) take a similar view of culture as "a set of learned behaviours, beliefs, attitudes and ideals that are characteristic of a particular society or population." An interpretivist perspective is reflected in other definitions. Spradley (1979, p. 5) defines culture as "the acquired knowledge that people use to interpret experience and generate social behaviour." Kleinman (1978, p. 86) describes culture as "a system of symbolic meanings that shapes both

social reality and personal experience.” Geertz (1973) views culture as socially constructed, where meaning structures provide the context for understanding and interpreting behaviour.

The definition of culture used in this study had to be congruent with the interpretivist perspective. An adaptation of Spradley (1979), Fitzgerald, Mullavey-O’Byrne and Clemson (1997) and Helman’s (2001) definitions were used. In this study, culture is defined as the *learned and shared values, beliefs and meanings that form the lens or perspective through which an individual understands and interprets his or her experiences.*

Culture, disease, illness, sickness and healing

Through this cultural lens people construct views of disease, illness, sickness and healing (Hahn, 1995). Using classical works (Good & Good 1981; Hahn 1995; Kleinman 1980) where the differences were first clearly articulated, there is general agreement that disease is a biological or psychological process. However, there are different views on the meaning of illness, sickness and healing.

Illness is described as the human experience of symptoms and suffering, and as a socially constructed experience (Fabrega 1997; Good & Good 1981; Hahn 1995; Kleinman 1980). Sickness occurs when the condition becomes known, recognised, interpreted and communicated into the world of meaning (Young, 1982). Littlewood (1989, p. 222) suggests that sickness is the totality of disease and illness. In this model, disease is a professional construction of the malfunctioning of the body

and illness is the personal and cultural understanding of a reaction to a disease. Young (1982) argues that sickness is a process for socialising disease and illness, which then determines the form of healing.

Fabrega (1997) describes healing as a socially constructed effort to neutralise illness. Kleinman (1980) distinguishes between the healing of disease and healing of illness. Curing, as a form of healing, is the control of the biological processes of disease. Healing of illness is the provision of personal meaning in relation to the sickness experience. On the other hand, Young (1982) challenges this individual focus of healing, and argues that healing is also an ideological practice that impacts on the distribution of illness and disease in society. My study uses a meaning-centred perspective where healing is a transaction across meaning systems (Good & Good, 1981).

Health beliefs and explanatory models

Differing approaches are taken in medical anthropology to explain health and illness behaviours. Health beliefs models take a positivist approach, while Kleinman's (1980) explanatory model and Good and Good's (1981) meaning-centred approach are based on a culturally situated meaning of illness. An overview of the aspects of health beliefs and explanatory models provides background knowledge to understanding patients' beliefs about illness and healing, which in turn relates to the role of nurses in caring within the nurse and patient relationship.

The health beliefs model is based on a positivist view that people behave rationally in order to achieve positive health, and that beliefs and behaviour can be measured objectively. The health beliefs model predicts that the person will take preventative health actions or comply with medical regimes in relation to their perception of the severity of the disease and their susceptibility. The person will also consider the perceived benefits as well as barriers to preventative actions (Mikhail & Petro-Nustas, 2001). The health beliefs model is criticised for being provider focused and failing to account for the effect of culture on health beliefs and behaviour. As noted by Good (1994, p. 43), “the ability of the individual to appraise symptoms, review available resources, then make voluntary choices is simply a myth for many in our society and in other societies.” The assumption that people make rational choices in the treatment of disease is complementary to the biomedical model and shows its derivation from research on White, middle class groups (McSweeney, Allen & Mayo, 1997). The positivist approach suggested by the health beliefs model makes it incongruent with the constructionist stance of this study.

Kleinman (1980) proposes the concept of explanatory models, which are the personal beliefs systems used to recognise, interpret and respond to the illness experience. Explanatory models are culturally based explanations of the mechanisms and expected treatments of the illness. These explanatory models are constructed through interaction with the environment, change over time and are related to a specific illness experience. Patients and healers often have different explanatory

models. Patient's explanatory models reflect a cultural view of their illness within their social world. Healers bring these cultural models to their professional practice and acquire additional explanatory models (such as the biomedical model) through professional training. In a biomedically dominated system, the health professionals' explanatory models are generally oriented towards a disease — a curing positivist model (Kleinman, 1980, p. 73), that places the patient's illness into a symptoms and disease nosology or scientific classification scheme (Campbell, 2000, p. 110).

Young (1982) suggests that Kleinman's model has limitations as the focus is on the patient-physician relationship and an illness event rather than the wider social issues related to sickness and health. Kleinman's explanatory model could also be criticised for promoting a dichotomy in the Western biomedical system between the physician and the lay patient where the physician gains the patient's compliance with the medical treatment regime. This study required an approach that interprets individual and collective experiences. Kleinman's focus on the individual episode of illness is therefore not the most suitable framework for this study; however, the general idea of explanatory models is of value from a conceptual view.

A meaning-centred approach

Good (1994) criticises the concept of humans as rational acting individuals and proposes the meaning-centred approach from an interpretivist perspective. There are two underlying assumptions about the

way meaning is created and presented. Meaning is established as a network of symbols and medical language provides the interpretive framework used to construct the personal and social realities (Good & Good, 1981). Networks of meanings are “the metaphors associated with disease, the ethno-medical theories, the basic values and conceptual forms, and the care patterns that shape the experience of the illness and the social reactions of the sufferer in a given society” (Good & Good, 1981, p. 176). The wider perspective of Good and Good’s meaning-centred approach provides an interpretive framework to explore the symbols, values, conceptual forms and caring patterns of the Arab Muslim nurses’ personal and social realities of caring.

Culture and health care systems

Health care systems are distinct cultural systems that are socially and culturally constructed (Hahn 1995; Kleinman 1980; Littlewood 1989). Health care systems are socially organised responses to disease and cultural systems that integrate the health related components of society. The components of health systems are beliefs about illness and healing, defined roles and interactions between healers and patients and institutions where healing takes place (Kleinman, 1980). Patients and healers are embedded in specific configurations of cultural meanings and social relationships. As Kleinman (1980) notes, in general the health professional’s explanatory model is oriented towards disease, while the patient’s model is directed towards the experience of illness as constructed through the person’s culture. Health care systems minimally include popular, folk and professional sectors. Various healing

professions make up the professional sector, with nursing as a medical subculture within the professional sector (Helman, 2001). In this study, it was anticipated that beliefs about illness and healing would be constructed from the religious and cultural values of Arab society and thus determine roles and interactions between the nurse and patient. These beliefs or explanatory models in turn inform the nurses' caring experience and meanings.

Cultural construction of caring

There is an extensive body of literature on caring in nursing with agreement that caring is a complex phenomenon. The term "caring" in nursing is widely used yet poorly defined and may be understood in different ways. "Care" may be used as a noun, as a verb "to care", may indicate actions performed as in "take care of," indicate a concern as in "caring about," or may encompass all of these. Many claim care and caring are the fundamental concepts that shape the practice of nursing and are central to the nursing paradigm (Brody, 1988; Leininger, 1995; Watson, 1990). Watson (1990) claims that caring is the ontological substance of nursing that underpins nursing epistemology.

Underlying debate on the nature of caring as the essence of nursing is the need for an agreed theoretical perspective. As explained by Morse, Bottorff, Neander and Solberg (1991, p.125), "if caring is the 'essence of nursing', the issue of which theoretical perspective of caring is most descriptive of this essence is vital." This lack of understanding, definition or agreed theoretical perspective is a common theme in the

caring literature and underpins the debate about the centrality of caring within the nursing paradigm. Additionally, the Western nursing paradigm is dominant in the research on caring in nursing as demonstrated in the literature reviews by Bassett (2002), Kyle (1995), Lea and Watson (1996), and Patistea and Siamanta (1999).

Quantitative and qualitative research into the phenomena of caring in the Western nursing literature reflects a lack of clarity and definition. For example, caring is considered a therapeutic intervention (Gaut, 1983; Larson, 1986; Leininger, 1991), an interpersonal intervention (Wolf, Giardino, Osborne & Ambrose, 1994) or a process (Cronin & Harrison, 1988). Two aspects are consistently identified: the instrumental or technical aspects and the expressive or affective and psychological aspects (Arthur et al. 1999; Begat & Severinsson, 2001; Burfitt, Greiner, Miers, Kinney & Branyon, 1993; Cronin & Harrison, 1988; Larson, 1986; Watson & Lea, 1997). The research indicates that patients value the technical aspects of care, while nurses place greater emphasis on the psychological aspects of caring (Kyle, 1995; Patistea & Siamanta, 1999).

Morse, Solberg, Neander, Bottoroff and Johnson (1990) analysed the concept of caring and identified five epistemological perspectives: caring as a human state, caring as a moral imperative or ideal, caring as an affect, caring as an interpersonal relationship, and caring as a nursing intervention. Caring as a subjective experience and the physiological response to it were identified as the outcomes of caring. It is not surprising that Morse et al. (1990) identified five epistemological perspectives as caring occurs in different cultural contexts and reflects the

dichotomy of the human science and biomedical science models in the nursing paradigm.

Quantitative researchers seek to reduce caring to underlying dimensions that can be measured (Lea & Watson, 1996). Many authors agree with Valentine's (1989) view that meanings and behaviours of caring are context specific (Bassett, 2002; Lea & Watson, 1996; Patistea & Siamanta, 1999). Kyle (1995, p. 512) explains that caring is more than a set of behaviours; it is a process that includes moral, cognitive and emotional components that are culturally derived. Leininger's (1991) theory of culture care builds on an anthropological perspective that caring is a social and cultural construction. "Human caring is a universal phenomenon, but the expressions, processes and patterns of caring vary among cultures" (Leininger, 1991, p. 11). Leininger focuses on caring acts directed toward health and well being, but does not encompass the technical or affective aspects of caring.

The underlying premise of this study was that forms of caring are culturally constructed so the epistemology of care and caring will reflect the context of the society and belief system where the caring experience occurs. Further evidence of the cultural construction of caring is found in the following discussion about the historical context of nursing and caring in non-Western cultural contexts.

Historical and cultural context

As a medical subculture, nursing has its own explanatory models and networks of meaning to construct and interpret experience as

developed through nursing history, professional socialisation and within the context of societies in which the profession evolved. As individuals, nurses enter the health system with their unique beliefs about health, disease, sickness and healing constructed from their cultural world (Fitzgerald, 1992). During the professional socialisation process or acculturation, the nurse adopts new scientific concepts from the biomedical model (Herberg, 1995), but does not necessarily supplant all knowledge and beliefs acquired in relation to the other domains (Fitzgerald, 1992).

Holden and Littlewood (1991, p. 3) suggest that nursing is “essentially a Western professional construct that developed within particular historical circumstances, and has been variously understood and interpreted in different societies,” while noting that there are many themes that cut across history and culture. Holden and Littlewood (p. 6) contend that while the content of nurses’ work may vary in different societies, the universal role of caring “is restating that particular society’s cultural values.”

The Anglo-centric view of nursing that pervades the nursing literature traces nursing history from the time of Florence Nightingale, when caring for the sick and nursing emerged from the dark ages in the mid-nineteenth century. Maggs (1996) explains that the development of nursing relates to the growth of medical knowledge, specialisation and hospital care as well as the transformation of societies related to industrialisation. Although various forms of caring for the sick existed well before the time of Nightingale, Western nursing is a construct of the

nineteenth and twentieth centuries, Historically, professional caring derives from the writings of Florence Nightingale and is formalised through conceptualisations of caring by theorists such as Leininger (1991), Watson (1988b) and Gaut (1983).

The Western construct of nursing is influenced by the biomedical model and social values. Herberg (1995) explains that nurses, at least in Western societies, have the same value system, beliefs and attitudes as the dominant middle class in America, and belong to a culture of nursing that comes from socialisation into the Western nursing profession's belief systems. Narayanasamy and Owens (2001) note that nurses in the United Kingdom health sector (and in other Western societies) are raised in a culture permeated with Christian traditions and a belief system that infers that nursing care will be delivered from a value system characteristic of that Christian heritage.

Maggs (1996) links cultural context and nursing history. An examination of the history of nursing in India demonstrates the relationship between historical context, cultural values and nursing values. References to ancient nursing in India are found in the classical works on Ayurveda medicine, where nursing was considered an integral part of the curative exercise (Somjee, 1991). Nursing remained strong until the decline of Buddhism around 300CE and the resurgence of Hinduism, which designated many acts of touching bodies as polluting. The impact of Hinduism on nursing was that many nursing actions were considered unclean and had to be delegated to the lower caste in society. The state of nursing declined for several hundred years and emerged again under

British colonisation and other Western influences in the late 1800s. The modern nurse caring role in India blends Ayurveda medicine and Western biomedical approaches within a social context that continues to relegate nurses to a lower caste in society as nursing actions involve touching human bodies (Somjee, 1991).

Caring in Eastern culture

The premise that caring is culturally constituted is supported by studies of nurse caring from Eastern societies. Wong and Pang (2000) explored the nature of nurses' caring in China. In Chinese medicine, illness is perceived as a state of disharmony between the individual and the natural and social environment where caring and curative processes are needed to restore balance and harmony in the individual (Chen, 2001; Wong & Pang, 2000; Wong, Pang, Wang & Zhang, 2003). The nursing role in caring for the sick encompasses a holistic model of care grounded in traditional Chinese medicine practices, Eastern ideologies and Confucian notions of *qing* (empathetic understanding, caring or concern for), *li* (truthfulness, responsibility), *zhi* (understanding, knowledge), and *xin* (action, interact) (Pang et al. 2004). Pang et al. (2004, p. 668) state that *qing*, *li*, *zhi* and *xin* constitute the epistemic concerns of nursing with Chinese characteristics. They note the similarity in focus to Western nursing; however, the fundamental values and ideologies are grounded in Eastern epistemology.

In another study, Holroyd, Yue-kuen, Sau-wai, Fung-shan and Wai-wan (1998) used the quantitative Caring Assessment (CARE-Q)

instrument to study Chinese cultural perspectives on nursing care behaviours in Hong Kong. Chinese and Confucian principles of hierarchical relationships and deferral to authority determined the nature of relationships between the nurse and the patient, doctor, and colleagues. According to these authors, the paramount obligation of the family to care for the sick and the concept of losing face if outsiders care for intimate personal needs shaped the nature of the caring for the patient. In addition, the need to stay calm, save face and avoid upsetting another reflects the Chinese cultural value of promoting social harmony. Yam and Rossiter (2000) found similar cultural values that impacted on caring by Hong Kong nurses.

In another cultural context, Shin (2001) examined the Korean worldview grounded in the Eastern philosophies of Confucianism, Buddhism and Taoism as the basis for nursing theory development in Korea. Taoism is identified as the dominant philosophy impacting on Korean nursing. In this philosophy, the universe is the balance of *yang* (positive or male elements) and *yin* (negative or female elements), and life is considered to be the circulation of *yang* and *yin* (Shin, 2001). Health is the harmony of *yang* and *yin* while illness is the loss of harmony and balance of the life rhythms. The nursing role is to recognise imbalance in a patient's condition and assist to restore the balance and harmony of life. In contrast to the Western biomedical focus on disease, the focus of nursing in Korea is on life itself, with the goal to bring about the harmony of *yang* and *yin* and strengthen the patient's *chung* (physical materials that make up the body), *khi* (energy that maintains the life, physical and

mental activities) and *shin* (spirit or soul). Shin (2001) notes that mutual trust and understanding between nurses and patients are established by sharing the common philosophy of Taoism.

The view that forms of caring are culturally constructed is further demonstrated in Spangler's (1991) comparative study of culture care of Philippine and Anglo-American nurses in an American hospital context. Anglo-American nurses' care was characterised by promotion of autonomous care based on informed decision making and control of situations. Patient teaching assisted in achieving patient autonomy and supported the nurses' demand for patient compliance with health regimes. In contrast, Philippine nurses' care was characterised by the obligation to care based on values of physical comfort, respect and patience. An emphasis on duty reflected cultural values of a hierarchical and authoritarian social structure. Given the contrast in the care values expressed by the two groups, it is not surprising that this study, and others, report nurse-to-nurse conflicts between Anglo and Philippine nurses due to cultural misunderstandings.

Context of caring in Middle Eastern nursing

This study was primarily concerned with the caring of Arab Muslim nurses from Saudi Arabia, Jordan, Egypt and Lebanon within the setting of Saudi Arabia. The greater Middle East region includes the Arab countries of Oman, United Arab Emirates, Bahrain, Qatar, Syria, Iraq and Kuwait. In all of these countries, Islam is the majority religion, ranging from 70% to 100% of the local population. A map of the region is included

(Figure 1) to assist the reader to orient to the geography. The countries of Egypt, Jordan and Lebanon are highlighted, as are the cities of Riyadh and Jeddah (Jiddah) in Saudi Arabia where the study was located.



Figure 1. Map of the Middle East region

The context of nursing in the Middle East draws on the interrelated aspects of Islam, Islamic health beliefs, the importance of family as the primary social unit, distinct gender roles and the perceived low status of nursing. Spirituality as grounded in the Muslim worldview is a theme that weaves throughout Arab culture and research on nurses' caring in the Middle East.

Islam

Islam means total submission and obedience to the will of Allah (Al-Shahri, 2002). The teachings and law of Islam derive from the Holy

Qur'an (the Holy book revealed to the Prophet Mohammad (PBUH)⁴ as Allah's last messenger) and the *Sunnah* (traditions, sayings and actions of the Prophet Mohammad (PBUH)). Islam provides guidance on personal, social, political economic, moral and spiritual affairs for the life of the individual and society and Muslims (followers of Islam) incorporate religion in all aspects of their lives (Rashidi & Rajaram, 2001).

There are two main sects in Islam: Sunni and Sh'ia. Ninety percent of Muslims are Sunni and the majority of the remainder are Shi'a (Winter, 2008). Sunni and Shi'a share articles of faith and the experience of Islam (Winter, 2008). Differences lie in the historical direction of political and spiritual leadership, with slight practical and doctrinal differences between the sects (such as prayer and fasting rituals). The Sunni sect is dominant in the Middle East, while the Shi'a are a majority in Iran, Iraq and Yemen. In this study, the majority of Arab Muslim nurses were Sunni.

The concept of *tawheed*⁵ is fundamental in Islam. *Tawheed* means "the Oneness of Allah," or "unification," which requires maintaining Allah's unity in all human actions: spiritually, intellectually and practically (Rassool, 2000). A practising Muslim lives in a way that reflects unity of mind and body with Allah. *Tawheed* implies there is no separation of body from the spiritual dimension of health: there is mind-body unity (Luna, 1995).

⁴ PBUH means Peace Be Upon Him. This is required whenever the name of the Prophet (PBUH) is written

⁵ There are two translated spellings commonly used: Tawhid and Tawheed

Muslims also believe in predestination (according to Allah's will) and life after death when, on the Day of Judgment, Allah judges people on their deeds during earthly life. There are five pillars or foundations of Islam that must be followed. The five pillars of Islam are: faith (*Iman*), prayer (*Salat*), alms or concern for the needy (*Zakat*), fasting (*Seayam*) for self-purification and pilgrimage to Mecca (*Hajj*) (Mahasneh, 2001). The profession of faith is the statement made by the person that he or she believes that there is no other God to worship but Allah, and Mohammad is the messenger or prophet of God. Prayer or *salat* is performed five times a day and is an essential part of daily activity. The giving of alms or *zakat* is a religious tax requiring a portion of wealth (2.5%) to be given to the needy. The purpose of *zakat* is purification and growth of the person (Mahasneh, 2001). Fasting is another method of self purification, whereby Muslims abstain from food, fluids, sexual practices and worldly comfort from sunrise to sundown during the Holy month of Ramadan. Through the act of fasting, a person gains sympathy for the less fortunate and grows spiritually through self restraint and patience. Finally, the pilgrimage (*Hajj*) to Mecca in Saudi Arabia is intended for all who are able to take the journey once in their lifetime. The rituals of the Hajj reinforce submission to the will of Allah and the equality of all persons before Allah.

The Islamic legal system (*Sharia*), derived from the Holy Qur'an and *Sunna*, aims to create a good environment for an individual's physical, mental and spiritual development (Yousif, 2002). *Sharia* (Islamic) law has five objectives: protecting life, safeguarding the freedom

to believe, maintaining the intellect, preserving human honour and dignity, and protecting property.

Islamic teachings on health are important for this study on Arab Muslim nurse caring. The Holy Qur'an teaches that Muslims must protect their health and strive to maintain a healthy environment. Health is seen as a gift from Allah and illness as a way of atonement for sins and greater reward in the afterlife. The existence of the evil eye and the *jinn* (spirits) are accepted as a cause of disease, with a belief that Allah has the overriding power to cause and cure illness. Spiritual healing by repetition of readings from the Holy Qur'an (called *ruqya*) has been used as a direct healing method since the beginning of Islam. Preservation of daily prayer rituals, traditional Arabic medicine, folk remedies, traditional healers and Western health care are also accepted sources of healing (Al-Shahri, 2002; Lovering, 2002). The impact of Islam on health beliefs and the explanatory models of nurses are examined further in the findings chapter on Explanatory Models of Health, Illness and Healing.

Arab culture

The themes of family, gender roles and spirituality pervade any discussion on Arab culture. Research on the caring experience of immigrant Middle Eastern populations serves to highlight these interrelated themes. While the studies are on caring of various Middle Eastern populations, these research results emphasise that cultural values must be maintained for caring to occur.

The meaning of the caring experience of immigrant Middle Eastern populations has been studied by several nurse researchers (Kulwicki, 1996; Kulwicki, Miller & Schim, 2000; Lipson & Meleis, 1985; Luna, 1994; Nahas & Amasheh, 1999; Omeri, 1997; Wehbe-Alamah, 2005). The common themes from these studies reveal the meaning of caring as defined within the worldview of Islam, the need to fulfil equal but different gender roles, the maintenance of family honour, family ties and preservation of traditional customs and health care practices. Many of these studies use an ethnonursing methodology based on a qualitative approach using Leininger's (1991) theory of culture care as the theoretical framework.

Luna's (1994) ethnonursing study of Lebanese Muslim immigrants to the United States identifies broad themes of caring: equal but different gender role responsibilities; the family obligation to care as embedded in the religious worldview of Islam; and care as individual and collective meanings of honour. An ethnonursing study of culture care meanings and experiences of postpartum depression among Jordanian immigrant women in Australia found similar themes of caring: fulfilling traditional gender roles as mother and wife; strong family support and kinship ties; and preservation of Jordanian childbearing customs (Nahas & Amasheh, 1999). The family caring theme also emerged from a qualitative study conducted with Arab Americans, where family caring values and behaviours were identified as the defining characteristics of Arab culture (Kulwicki et al. 2000). Confirmation of the cultural values of family, maintaining gender roles and importance of spirituality is found in Miller

and Petro-Nustas' (2002) study on the context of care for Jordanian women in Jordan. The themes that emerged related to similar cultural values of family honour, religious influences, connectedness within the family, and gender roles.

Spirituality and its relation to health is a key issue. Emami, Benner and Ekman (2001) studied the meaning of health for Iranian late-in-life immigrants. They observed that “a spiritual sense of connection to family, others, and a spiritual sense of unity and beliefs about God and God’s will inspired their reflections and beliefs about life and the meaning of health and illness” (p. 19). Western ideas of needing to be in charge or take control are in contrast with the Eastern vision of harmony with one’s destiny. An examination of health meanings of Saudi women (Daly, 1995) supports this view, where practicing healthy ways, performance of roles, harmony in life and spirituality have greater emphasis than health categories of being productive, adaptable and maintaining physical fitness.

Historical context of nursing

In the Middle East, caring takes place within an historical context of nursing that predates the era of Florence Nightingale. The first nurse identified in Islamic nursing history was Rufaidah bint Sa’ad, who lived during the time of the Prophet Mohammad (PBUH) in the 8th century (CE). Like Nightingale, Rufaidah set up a training school for nurses, developed the first code of conduct and ethics, and was a promoter of community health. She cared for patients in a tent erected outside the Prophets’

(PBUH) mosque and led nurses in caring for the wounded during the time of the Holy Wars. The history of Rufaidah and other nurses at this time is recorded in the *Sunnah* (Al-Osimy 1994; Jan 1996; Kasule 1998). The recognition of Rufaidah as the first Muslim nurse and role model is a very recent phenomenon as Saudi nurses looked to their religion and history to place the nursing role within their religious framework (Lovering 1996). Muslim nurses' history parallels the history of Islamic medicine, as great hospitals were built in Damascus, Baghdad and Cairo and medical knowledge was transferred to medieval Europe and later contributed to the European Renaissance (Rassool, 2000). The narrative, or story, of Rufaidah is explored extensively in the chapter on The Meaning of Caring.

Society views and the status of nursing

Society views nurses in the Middle East as having a low status and compromised moral standing (El-Sanabary, 1993, 2003; Fullerton & Sukkary-Stolba, 1995; Jackson & Gary, 1991; Kronful & Affara, 1982; Mansour, 1992; Meleis, 1980). Low status relates to low academic achievement (Fullerton & Sukkary-Stolba, 1995), ill-defined roles, demeaning work, the confusion of multiple levels of entry into practice and dominance of the medical profession over nursing education, practice and management (Al-Aitah, Cameron, Armstrong-Stassen & Horsburgh 1999; Boyle 1989). The moral issues relate to the cultural taboos against mixing of genders in work places and a history of nurses coming from lower classes in society. The society's lack of respect for nurses and the lack of status of nursing as a profession mean few are willing to study nursing and families are reluctant to let their women enter nursing (Meleis, 1980,

p.292). Many will take nursing as a second choice when they are unable to enter the medical profession due to lower academic achievement (Boyle, 1989, Lovering, 1996).

Nursing education

There are generally four levels of education to prepare nurses in the Middle East: high school certification (similar to nurse aid level), diploma (2 years post high school), associate degree (3 years post high school) and bachelor degree (4 years post high school plus one year of internship). There are some masters degree programs in Saudi Arabia, Jordan, Lebanon and Egypt, and one doctoral program in Jordan. Nurses seeking masters or doctoral degrees usually travel to the United States or the United Kingdom for postgraduate study. The majority of nurses in the Middle East have a diploma level education (high school or post secondary), which contributes to the perceived low academic standard of nurses (Al-Darazi, 2003).

The history of nursing education in the region reflects the influence of British, French and American colonisation in the Middle East. Christian missionaries and nuns were instrumental in beginning the training of nurses in Jordan, Lebanon and Syria. British and American influence on nursing education continues to the present day in development of college and university nursing programs, where the Western model of nursing is the basis for the nursing curriculum. Al-Darazi (2003, p. 175) notes that “in most countries of the region, nursing curricula were founded on the Western medical model, stressing individual and curative hospital care.”

The quality of nursing education is variable, compromised by limited resources and lack of a systematic approach to the accreditation of programs (Al-Darazi, 2003). Language and culture are two issues of concern. The majority of resources for nursing education are in English and reflect the Western approach to nursing care. At the diploma level, in particular, students have poor English language skills and are not able to use resources such as nursing textbooks, academic journals and other publications. According to Al-Darazi (2003, p. 178), “the majority of nursing schools have inadequate teaching — learning materials that are in national languages and culturally relevant.” At a university level, the language of instruction is English and resources are more comparable to a Western academic setting.

Nurse migration

Economic disparity in the region contributes to local patterns of Arab Muslim nurse migration to neighbouring countries with more (oil-rich) resources. As only 10-20% of nurses in the resource-rich Arab Gulf countries of Saudi Arabia, Kuwait, Bahrain, United Arab Emirates (UAE) and Qatar are educated and work in their home country, there is a reliance on foreign nurses (Tumulty, 2001). Nurses from Jordan, Egypt, Syria and Lebanon migrate to these Arab Gulf countries for better work opportunities and higher salaries (Petro-Nustas, Mikhail & Baker, 2001). Male nurses, in particular, from Jordan and Lebanon seek higher paid positions in the neighbouring Middle East countries (Al-Atiah, et al. 1999; Petro-Nustas et al. 2001).

Nurses' caring in Arab culture

There is limited research that addresses the cultural aspects or nurses' experiences of caring within the context of Arab culture. Research on the cultural aspects of caring within the context of Arab culture suggests spirituality as the basis of nurses' caring, as well as values associated with gender-based caring.

Mebrouk⁶ (2004) studied perceptions of nursing care by Saudi female nurses using an interpretive approach. Islamic values provided the framework for nursing care. Mebrouk (2004) describes the impact of Islam on the caring experience as a taken-for-granted concept, where the patient and nurse had shared values. The role of communication in the nurse-patient relationship was similar to that expressed in Western nursing. However, gender differences impacted on the nature and role of touch and eye contact between female nurses and male patients, reflecting Arab culture and religious teachings.

Fooladi's (2003) ethnographic study of gendered nursing education and practice in Iran uncovered professional values impacting on care that reflected the Islamic faith. In their professional values, nursing and caring concepts were one act of faith. Spirituality and caring for or about a human being was considered a form of prayer and a spiritual activity.

⁶ Mebrouk's study (2004) was exploratory in scope with a sample size of five participants and completed as part of a masters' degree. The thesis was of particular relevance to my study of Arab Muslim nurses' caring as a source of secondary data and validation of findings.

Fooladi (2003) also noted a gender difference reflecting Iranian culture. Female nursing students placed greater emphasis on the holistic and spiritual aspects of caring, which is consistent with Iranian views on female values. In contrast, males were less interested in aspects of holistic or compassionate care and viewed nursing as a source of income and a means to earn a living.

Al-Helwani's (2001) ethnographic study of the care expressions, behaviours and patterns of Saudi Arabian male patients undergoing haemodialysis described the role of religion from the patient's perspective. Patients believed that health and illness come from Allah and religion was crucial to life's success. Caring was described as a cultural and religious obligation, and gender segregation was expected.

The contention that nursing's role in caring is constructed by cultural values is reflected in recent calls to develop a nursing model that reflects Arab culture and Islamic health beliefs. AbuGharbieh and Suliman (1992, p. 152) raised concerns about the influence of the American philosophy of nursing on the university curriculum in Jordan and suggested that "nurses must decide whether the American version of nursing ... fits Jordanian culture and society." Rassool (2000) identified the need for an Islamic model of nursing, based on the Islamic perspective of caring and spirituality as embedded in Islam's theological framework. Rassool (2000, p. 1481) explained that the concept of caring is embedded in Islam's theological framework and expressed at three levels: intention, thought and action. He argued that nursing models from the Judeo-Christian tradition are devoid of the core of spirituality and

religious covenant, and therefore are inappropriate in meeting the holistic needs of Muslims in Islamic and non-Islamic societies. The need for a model of nursing based on Islamic beliefs to ensure congruence between the Islamic nursing identity and the practice of nurses was identified in my earlier study of Saudi nurse leaders (Lovering 1996, p. 66).

Summary

This background chapter provides a tapestry of context within which the study of the Arab Muslim nurses' meaning of caring was carried out. The constructionist theoretical perspective (Denzin & Lincoln, 2000; Koch, 1999; Mishler, 1981; Schwandt, 2000) guided the construction of meaning through an interpretive process (Crotty, 1998, Davies, 1999). This chapter explored various approaches to explain health and illness behaviours, with the meaning-centred approach (Good & Good, 1981) selected as the most congruent approach within a constructionist stance.

The premise that caring in nursing is culturally constituted is supported by studies of nurse caring in Eastern societies. The story of Rufaidah as the first nurse in Islam places nursing in the Middle East within an historical-religious context. I expected that Islamic health beliefs and the biomedical model would blend to form a culturally distinct model used by Arab Muslim nurses in their beliefs about health, disease and healing. Through uncovering the explanatory models used by nurses in their practice, I anticipated that an understanding of the meaning of caring as experienced by the nurses would emerge. The next chapter sets the direction and describes the ethnographic methodology used to

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understand these explanatory models and the ways beliefs shape the nurses' caring experiences.

Chapter 3: Methodology

Introduction

The focus of this study was to identify the cultural patterns that provided reason and meaning to the nurses' health beliefs and caring experiences. This chapter briefly describes the ethnographic approaches of Geertz (1973), Fitzgerald (1997) and Davies (1999) that guided this applied ethnographic study. A description of the Arab Muslim nurses participating in the study, as well as reflections on my background, religion and cultural understanding of the study context is given.

Consistent with ethnographic methodology, data generation and analysis was a simultaneous process with multiple methods of data generation and analysis used in accordance with the approach of Fitzgerald (1997). A detailed description of the path of data generation, analysis and validation as outlined in this chapter (see also Appendix A) demonstrates the process of developing rich data embedded in the cultural context, the integration of data with theoretical formulation and the reflexive ethnographic process (Davies, 1999). Prolonged engagement and immersion in the cultural world of Arab Muslim nurses over a four year period (2004 — 2007) as documented in extensive field notes contributed to achieving results that are accessible, relevant, significant and credible. The experience of obtaining ethics approval is shared to address the complexity of ethics within this cultural and ethnographic process.

Ethnographic methodology

Ethnography is a description and interpretation of a cultural or social group or system to discern pervasive patterns of daily living and incorporate the views of the group and the researcher's interpretations (Creswell, 1994). Ethnography is variously described as "thick description" in the study of culture (Geertz, 1973), a description of the social and cultural worlds of a group (Emerson, 1983), the work of describing a culture (Spradley, 1979), or a description of cultural knowledge of the participants (Maggs-Rapport, 2000).

A broad view taken by Fitzgerald (1997, p. 57) describes ethnography as a state of mind, a way of viewing and understanding the world, and an analytical framework. As such, ethnography is concerned with understanding meanings, purposes and motivations underlying human phenomena. Fitzgerald builds on Geertz's (1973) description of ethnography as thick description and suggests that ethnographers use a multi-method approach to data collection and analysis to gain an in-depth understanding of the phenomenon of interest. The research question guides ethnographers and "the need to develop description that embeds the phenomenon in its context" (Fitzgerald, 1997, p. 53).

Reflexive ethnography (Davies, 1999) recognises the involvement of the researcher in the society and culture under study and the relationships between researcher and participants, which becomes the basis of subsequent theorising and conclusions. Reflexive ethnography acknowledges the active role of the researcher and the participants in

production of the data, where researcher and participants are engaged in co-constructing a world. This social reflexivity may be explicit or implicit as revealed through the interpretive insights of the ethnographer (Davies, 1999, p. 8).

Narratives and critical incidents are recent techniques used in qualitative methodology to explicate the meaning of experience. Narratives are stories used to make sense of or to uncover the meaning of an experience (Aranda & Street, 2001; McCance, McKenna & Boore, 2001; Schaefer, 2002) and to communicate cultural understandings within a specific context (Campbell, 2000; Fitzgerald, 2000). Kleinman, Eisenberg and Good (1978) link culture, meaning, and experience through the use of narratives. Narratives have been used to study caring and nursing, as caring is a complex and contextual concept with varying dimensions (Aranda & Street, 2001; McCance et al. 2001; Schaefer, 2002). Critical incidents are a subset of the narrative technique often used in ethnographic methodology. A narrative is a story with a resolution; whereas a critical incident is a narrative with an issue to be resolved or the need to attach meaning to the situation (Fitzgerald, 2001). "Critical incidents are discrete occurrences or events that require some attention, action, or explanation; they are situations for which people have a need to attach meaning" (Fitzgerald, Williamson, Russell & Manor, 2005, p. 335). Many narratives, including some related to this research, revolve around critical incidents as part of sense making or meaning making of events and actions related to caring.

This study used the ethnographic approaches of Geertz (1973), Fitzgerald (1997) and Davies (1999) to provide a broad approach to synthesising the complex interplay between Arab cultural values, Islamic beliefs, the professional values of the nursing system as a distinct cultural system, and the explanatory models used by Arab Muslim nurses in their practice. This use of multiple methods and a reflexive approach (Davies, 1999) led to thick description and an interpretive view of the caring experience from which an understanding of the meaning of care in the context of Arab culture emerged. Use of narratives and critical incidents grounded the knowledge and experiences of the nurses within their cultural context and assisted in the co-construction of the meaning of nurses' caring experiences.

Arab Muslim nurses as participants

This study was situated in Saudi Arabia and involved nurses from Saudi Arabia, Lebanon, Jordan, Egypt and Oman in caring for Arab Muslim patients. The majority of nurses worked within the hospital or nursing education setting. I will give a description of three distinctive groups who have voices in this study that form a collective view of the meaning of caring.

Arab Muslim nurses at KFSHRC - J

The first group are the Arab Muslim nurses with whom I interacted on a daily basis through our shared commitment to our patients in my role as the Chief of Nursing at King Faisal Specialist Hospital & Research Centre (KFSHRC-J) in Jeddah, Saudi Arabia. In this setting, Arab Muslim

nurses of both genders provide care to Arab Muslim patients (predominantly Saudi) or hold nursing management or clinical teaching positions within the inpatient or outpatient setting. They hold diploma, associate or bachelor degrees in nursing from a university or college in their native country. Their experience ranges from being a new graduate nurse to over twenty years of experience caring for patients. The technical nature of their nursing work is similar to that of a Western hospital setting where patients receive medical treatment within different specialities (such as surgery, oncology, cardiology, maternity care, etc).

The hospital facilities are of a high standard and recognised within the Middle East region for state of the art medical and nursing care. In this hospital, Arab Muslim nurses make up about 25% of the total of 800 nursing staff. They share their nursing world with Filipinos (50%), South Africans (15%, including all ethnic groups of South Africa) and Western (10%, from Europe, United Kingdom, New Zealand, North America). Arab Muslim nurses participated directly in the study through focus group discussions and indirectly through case study discussion, conference presentations and feedback, and interactions during patient rounds. I often commented that “every day is an ethnographic moment” in my daily interactions with the Muslim and non-Muslim nurses, Saudi patients and Arab Muslim physicians in this work context.

Nursing faculty participants

The second distinctive group are from the nursing education setting. The participation of nurses from college or university nursing

schools in Saudi Arabia was extensive. The Dar Al Hekma College Nursing Program in Jeddah has a collaborative partnership with KFSHRC-J, with faculty holding joint appointments and nursing students receiving clinical experience within the hospital. The head of the program, Dr. Sawsan Majali, a Jordanian, was an expert insider for this study. Other faculty (4 individuals) from this college were involved in focus group discussions, conference presentations, interactions during students' clinical experiences and were key participants in the validation process. Another group of nursing faculty (5 individuals) who had participated in my previous research on Saudi nurse leaders (Lovering, 1996) took on the role of expert insiders by giving individual advice, participating in group discussions and the validation process. A further group of nursing faculty (5 individuals) from nursing colleges in Riyadh participated in the first round of individual interviews at the beginning of the study. All faculty in this group were female. All education is segregated by gender in Saudi Arabia and education of male nurses is limited to diploma level only. My study happened to involve bachelor degree level nursing faculty so in effect excluded male faculty participation.

Arab Muslim nurses (general)

The third group of Arab Muslim nurses of both genders worked in other hospitals within Saudi Arabia, Oman and Lebanon. Some participated through the initial round of group interviews (a total of 12 participants) in Riyadh. Numerous others participated at various nursing conferences (10 conferences in total) in discussions about Arab Muslim nurses' caring after my presentations on the topic (Lovering, 2004a,

2004b, 2004c, 2004d, 2005a, 2005b, 2006a, 2007b, 2007c, 2007d).

Within this group are also the presenters at these conferences who covered a variety of topics related to caring and Middle Eastern nursing.

On the subject of religion and my cultural understandings

As the background of the researcher is critical to the interpretation of data, some information about me is important. My own cultural and religious background is that of Western Anglo-Saxon Protestant. I was raised in a conservative rural setting in Canada, where the local church is an integral part of the community. My nursing career in the past thirty years has exposed me to multiple cultures and hospital settings in Canada, the United States, New Zealand and Saudi Arabia. My interest and experiences in working within different cultures led me to advanced education in transcultural nursing and achievement of certification with the Transcultural Nursing Society in 1998 and recertification in 2005.

At the time this study began in 2004, I had worked in Saudi Arabia for 11 years as a senior nurse executive. As such, I am familiar with the Arab culture and have to a significant degree acculturated. I completed a master's research project on *Career Choices and Experiences of Saudi Nurse Leaders* (Lovering, 1996) using a grounded theory methodology eight years prior to starting the current study. During the first study, I gained knowledge of intercultural communication and an appreciation of the all encompassing impact of Islam on daily life in Arab culture.

A question to address is the ability of a Western non-Muslim to investigate the cultural world of an Arab Muslim nurse within the context

of Arab Muslim society. I knew it was vitally important to gain an understanding of Islam and how Islam integrates within Arab culture. Being an “outsider” to the religion and culture was an advantage and a disadvantage. Islam and the Arab culture are integrated to a degree that it is often difficult to determine if action or behaviour is a religious requirement or a cultural interpretation. As an outsider, it was easier to distinguish the unique aspects of the culture and religion expressed in the Arab Muslim nurses’ caring, but taken for granted by them as a natural aspect of caring. I was keenly aware that I had to gain a deep understanding of Islam and the basis for the health beliefs. I continually asked my insider experts and the participants in the study: “What does this mean?” “How does it fit?” “What was similar and what was different to my worldview?”

I needed to understand the links between my own religion (Christianity) and Islam through reading and discussion. An insider expert explained how each religion built on the other. She noted that the Jews brought the faith (“there is God”). Christianity brought the human perspective and human relations (“how to interact as humans”). Islam built on these beliefs by putting laws to regulate the way of life (such as punishment for stealing, murder). I read numerous articles and books written for non-Muslims by Muslims on aspects of Islam and Christianity as well as sections in the Qur’an referring to Christianity. This examination of my own religion in light of the Muslim perspective helped me to eventually understand the fundamental difference between the concepts

of transcendence in Christianity and tawheed in Islam (see discussion in Chapter 9, pg. 198).

While I received confirmation from participants that I understood and was representing the Islamic view correctly, I was always a bit nervous presenting to audiences that were primarily Muslim, such as during conference presentations. There were two distinct occasions that confirmed that I had grasped the essential beliefs of Islam, the integration of these beliefs within the worldview of Muslims and in the world of nurses' caring. In early 2005, I presented "The Context for Caring in Middle Eastern Nursing" (Lovering, 2005b) at an international nursing conference in Oman. This presentation covered health beliefs in Islam and the nature of spirituality in the health experience. After the presentation, Muneera Al-Osimy, a well known leader in nursing in Saudi Arabia, asked me if I had become a Muslim, "as you understand the religion so well."

During the validation focus groups at the end of the study, the nurses confirmed that the findings accurately represented their belief system. One nurse, a former dean of a school of nursing, commented: "I am embarrassed that it has taken a non-Muslim to figure out how our belief system is used in our nursing." This led to a discussion on how belief systems are a taken-for-granted concept, and how it is difficult to articulate your own belief system and how it is enacted. I shared how I found it difficult to explain my Western-derived belief system to Arab Muslim nurses. While caring actions are purposeful, the beliefs informing the actions are not always explicit.

English was the primary language of this study and the working language of the hospitals and academic settings. Participants translated when they used Arabic words during conversations. On occasion it would have been useful for me to have more Arabic skills than my rudimentary level. In compensation, and thereby turning a potential disadvantage to an advantage, I made it critical to my research to continually confirm my understanding of the culture, religion and meaning of concepts with expert insiders, thereby enhancing the reflexive process and integrity of the study.

Data Generation

The purpose of data generation was to achieve a thick description that went beyond a superficial description of the phenomenon to enable a detailed understanding of the setting, cultural context, and the informants' meanings and interpretations of their experience (Minichiello, Fulton, & Sullivan, 1999). Multiple, integrated strategies were used for data generation, analysis and validation. These strategies were: participant observation during daily interactions with Arab Muslim nurses and nursing students working in a tertiary hospital setting; international and national conference presentations and discussions on the topic; tape recorded and transcribed unstructured individual and group interviews; nursing ethics discussions, review of documents related to the topic; and validation focus groups. The elicitation of narratives and critical incidents was encouraged as part of describing the experience of caring by the nurses. The relative contribution of these data sources is displayed in Figure 2.

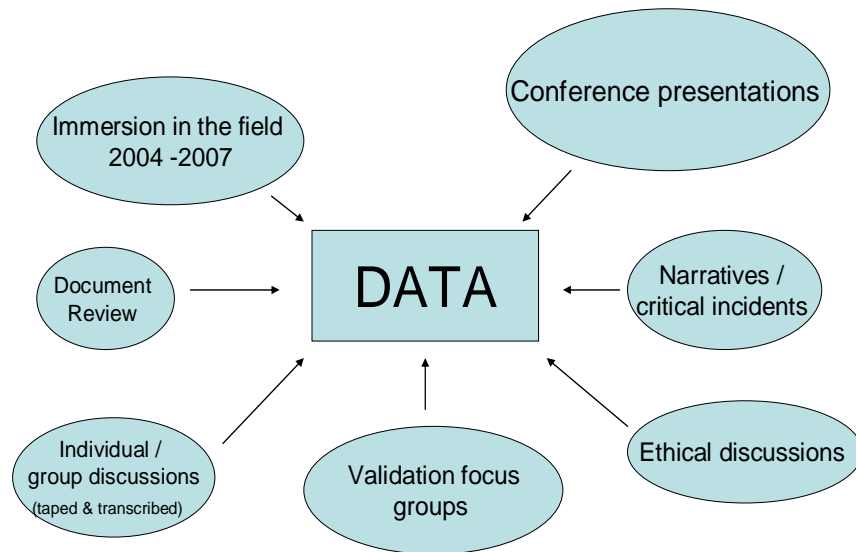


Figure 2. Relative contribution of data sources

Data generation focused on answering the questions: 1) What is the explanatory model used by Arab Muslim nurses in the caring experience? 2) What is the meaning of caring as expressed through the narratives of Arab Muslim nurses?

Conference presentations

Data generation began with four conference presentations over a three month period on “The Context for Caring in Middle Eastern Nursing” (Loving 2004a, 2004b, 2004c, 2004d). These presentations gave an overview of the history of nursing in Islam, Arab cultural and religious beliefs about health and research on the caring experience of immigrant

Middle Eastern populations within a Western cultural context. The theme of spirituality in caring emerged during discussions following the presentations. I had not planned to use conference presentations for data generation. However, as the local nursing community became aware of this study nurses wanted to contribute to the study in various ways. The presentations and discussions yielded rich data and the project became known to an even wider nursing community within and outside of Saudi Arabia. As the study evolved, further conference presentations incorporated emerging findings and themes (Lovering, 2005a, 2005b, 2006a, 2007b, 2007c, 2007d) and discussions during these conferences reinforced the reflexive ethnographic process. Data were captured through extensive field notes and reflective journaling related to these conference interactions. This process became an important part of the data generation, analysis and the validation process.

Interviews and group discussions

Two unstructured individual and four group discussions (involving a total of 14 nurses) were held in the initial three month phase in 2004. The initial interviews became group discussions as the interviewees invited colleagues to join the “interview.” After the first group discussion, I realised that the interactive nature of group discussions yielded rich data that were naturally interpretive in nature due to the use of narratives and critical incidents. Participants in the individual and group interviews came through various contacts: the individual interviewees were directly approached as expert insiders and leaders in nursing education or management; two group interviews involved staff nurses at two hospitals

who were approached through their direct managers to participate; two group interviews involved nursing faculty at the local colleges who were known to me through previous contacts. All interviews lasted 60 – 90 minutes, were tape recorded and transcribed with the permission of the participants through the informed consent process outlined in the ethics process described later in this chapter.

Immersion in the experiences of Arab Muslim nurses' caring

When planning the study, I intended to use individual and group interviews as a primary source of data to capture the narratives and critical incidents of nurses caring for patients. At the time, I was working in a tertiary eye hospital in Riyadh, Saudi Arabia, where the nurses were all non-Saudi, and the majority non-Arab Muslim. As such, I lacked immersion in the experience of Arab Muslim nurses caring for patients to be able to capture the meaning inherent in their caring.

In August 2004 (six months into the study), I relocated to Jeddah, Saudi Arabia, where the experiences of caring by Arab Muslim nurses was more accessible by the nature of my new work environment at the King Faisal Specialist Hospital & Research Centre - Jeddah. The strategy for data generation shifted to a more reflexive approach, using participant observation derived from my daily work experience and interaction with Arab Muslim nurses working at the hospital and the Dar Al Hekma College Nursing Program. These interactions were extensive and reflexive, involving discussions about the care given to their patients

during nursing rounds (in my role as the administrator), group discussions about ethical issues and patient care problems, case study presentations, conference sessions, educational sessions, and participation by these nurses in focus groups as part of validating the findings. Interactions were recorded as field notes with reflective comments that integrated with my insights into the evolving findings.

Nursing ethics discussions

Exploration of the ethical aspects of caring was not an intended focus of this study, but the topic emerged as an important dimension of nurses' caring. Towards the latter part of the study, in early 2007, I was involved in planning a session on ethical dilemmas for a nursing conference in Jeddah. For it I explored the cultural aspects of ethical decision making and prepared a presentation on "Nursing Ethics through a Cultural Lens" (Lovering, 2007a). In developing this presentation, I talked to Arab Muslim nurses about the ethical dilemmas they faced when caring for patients. Their experiences became the basis for case studies presented to an expert panel on "Ethical Perspectives at the Bedside" (Al-Swailem & Lovering, 2007) at the same conference.

The process of examining the cultural aspects of nursing ethics, discussions with the Arab Muslim nurses on ethical dilemmas and the expert panel discussion yielded rich data about the caring experiences of Arab Muslim and non-Muslim nurses that I recorded in field notes and reflective journaling. In addition, development of a diagram (Figure 3) to represent the "Ethical decision-making approach for nurses in an Islamic

predominant health care environment” was the starting point for further diagrams that evolved into a model of caring. Thus an exploration of the ethical dimensions of caring became part of the analytical process and forms the basis of Chapter 6.

Data analysis

Fitzgerald (1997, p. 48) argued that ethnography is both a process and a product, and both are inherently analytical. Multiple methods of analysis are required given the variety of data generation methods and richness of the data generated and “the most significant analytical process is that which goes on in the ethnographer’s head” (Fitzgerald, 1997, p. 54). The purpose of analysis is to organise and synthesise the data into a meaningful whole with strict triangulation of multiple and independent data points to create meaning and understanding of the phenomenon of interest. Reflexive ethnography requires that the ethnographer’s path in conducting fieldwork, the relationships between ethnographic data and the theoretical influences are made explicit in the analysis (Davies, 1999, p. 199).

Initial categories (concepts)

Davies (1999) suggests the development of an initial set of categories as low level theoretical concepts for classifying and thinking about the data so that emerging theories can be tested and refined. While coding of data may have some initial benefit for getting a sense of the data, Geertz (1973), Fitzgerald (1997) and Davies (1999) advise against an emphasis on coding as a primary analytical process, as coding data

can keep the analyst from going beyond a superficial understanding of the data and achieving thick description.

The initial interview transcripts and field notes from the first twelve months were coded to develop some initial categories, or themes. From this initial sorting, the relationships between different concepts and embedding the concepts within cultural context and meaning could occur. The initial categories included the following core concepts:

Gender (dignity, privacy, modesty, covering, gender segregation, society views, touching, protection, genital care, sexual harassment),

Islam and health (health meanings, balance, religion, Qur'an, health definition as physical, spiritual, psychological needs).

Caring role (technical, interpersonal, social, mental, physical, spiritual care, psychological care, family care, obligation to care, teaching, healing, relieve pain and suffering, humanistic caring, helping, clean wounds, human needs).

Nursing history (society view, Rufaidah, cultural sanction, first nurse, university teaching).

Religion and nurse caring (use of religious words, belief in God, prayer rituals, facilitate prayer, get reward from God, meaning for care, God blesses nursing role, work is prayer, guides nursing role, religion is strength).

Nurse/patient relationship (protection, respect, human connection, interpersonal, family, touching, eye contact, communication, language).

Ethics and spirituality (centre of relationships, consent issue, ethical issue, religious ethics, morality of nurse).

Ethnographic moments

Ethnographic moments were another tool for reflexive data generation and interpretation. Fitzgerald (2006, p. 6) refers to ethnographic moments as the “critical incident, moment, experience, event that evokes a quest for knowledge or understanding (meaning) or sudden insight into a phenomenon of interest” and noted that “it is often the uncommon comment or behaviour, or one that initially does not appear to be related to anything else, which provides the key that opens the door to insight and understanding, and hopefully, the progressively deeper levels of understanding” (Fitzgerald, 1997, p. 55).

I used the insightful comments and ethnographic moments in presentations, group discussions and individual conversations to further explore the meaning of a concept and validate my understandings with the participants. Ethnographic moments occurred early in the study and became an important focus for the reflexive process. The key insights that emerged early in the study are exemplified by quotes such as: “I read about nursing from the West, I think about nursing from the East”; “spiritual needs come before the physical needs”; “we are angels in the air”; and “Islam is central to nurses’ caring.” Through these insights, I gained a deeper understanding of the nurses’ distinct cultural model of caring where professional (Western) values are incorporated into the nurses’ existing cultural value system.

The recognition of the centrality of Islam in nurses' caring was a key ethnographic moment and turning point in this study. My analysis and theoretical formulation shifted to placing Islam at the core of caring, rather than being an influencing factor. Subsequent presentations and theoretical formulation (including creation of the model of caring) with Arab Muslim nurses built on Islam as the foundation to caring.

Narratives

Participants conveyed their cultural beliefs and shared their experiences of caring and related issues through narratives. Sharing narratives contributed to the theoretical co-constructions inherent in reflexive ethnography during discussion of insightful comments, ethnographic moments and emerging themes. Examples of these narratives are found extensively in the Meaning of Caring chapter.

I also used narratives to develop interpretation, such as the story of Rufaidah, or to recognise an area for attention, such as the place of gender in the caring experience. The story of Rufaidah and development of the chapter on Cultural Caring — Protection of Dignity are examples that show the use of narratives and critical incidents as vehicles for the interpretation of the caring experience. Critical incidents were a primary source of interpretation during discussion of ethical dilemmas in the ethics case studies.

Analytical writing and use of illustrations

Analytical writing became the process to integrate the multiple data points and interpretations to create thick description grounded within the

cultural meanings and religious context of the Arab Muslim nurses. I wrote short papers as a tool for reflection and theorising from my data on Islam and health beliefs and on the cultural construction of nursing. These papers contributed to the conference presentations (Lovering, 2005a, 2005b, 2006a) and reinforced the reflexive ethnographic process.

I then turned to my research questions and the findings started to fall into distinct themes that became chapters: Islam and health (explanatory model), caring as act of spirituality (meaning of caring), the ethical dimensions of caring and protection of dignity (cultural caring action). Within each of these themes, data and theories were integrated from narratives, reflexive discussion groups, religious writings, conference presentations, discussions with expert insiders and reflective journal notes to create an interpretive thick description as presented in the findings and discussion chapters.

Validation of findings: A reflexive process

A reflexive process (Davies, 1999) validated the findings and co-constructed further theoretical models. The findings were presented at a major nursing conference in Jeddah (Lovering, 2007b). I then drew a series of diagrams to represent the nurses' explanatory model (Figure 4) and the components of caring (Figure 5) for use in a focus group validation process.

Dr. Sawsan Majali⁷, an insider expert, reviewed the findings chapters and diagrams and proposed the concept of “shared meanings” between nurse and patient. Together, Dr. Majali and I co-constructed another diagram (Figure 6) to illustrate the shared meanings concept and incorporated this into a modified diagram of the components of caring. These diagrams and the study findings were presented to four validation focus groups (each with 6 – 10 people) representing hospital nursing staff (2 groups) and nursing faculty (2 groups). The focus groups co-constructed a final conceptual diagram that represented the meaning of caring for Arab Muslim nurses (Figure 7). A complete description of this validation process and co-construction of the meaning of caring through these diagrams is given in chapters 8 and 9.

The findings associated with these diagrams (Figure 4, Figure 6, Figure 7) were presented again at a major nursing conference in Riyadh (Lovering 2007c), as well as a hospital grand rounds (Lovering 2007d) for physicians and nurses. The grand rounds presentation was well received by the predominantly Arab Muslim audience, with extensive discussion on the transferability of the cultural and religious aspects of caring to the physician-patient relationship.

⁷ Dr. Sawsan Majali is the Nursing Program Director, Dar Al Hekma College in Jeddah, Saudi Arabia. Her name is used with her permission.

The ethics experience

Institutional ethical requirements for this study were extensive in Saudi Arabia and the approval process contributed to some delay in beginning the project. Ethics approval was required from my employers in Saudi Arabia as well as the University of Sydney. On a positive side, engagement of the ethics boards in Saudi Arabia ensured that cultural and religious ethical aspects were carefully addressed within the local context and, in turn, garnered support for the project from the local community. The project required two levels of ethics committee approval (Research Council and the Institutional Review Board) at the King Khaled Eye Specialist Hospital in Riyadh Saudi Arabia as the first ethics application process. This took 4 months to complete (August – November 2003). As these committees were not versed in qualitative methodology or more specifically ethnographic methods, I met with both committees to explain the methodology and address their concerns that the research would be respectful and accurate from the cultural and religious view.

The project was then submitted for approval to the University of Sydney Human Research Ethics Committee in December 2003; receiving approval in February 2004. After relocating from Riyadh to Jeddah in August 2004, submission to the Institutional Review Board of King Faisal Specialist Hospital & Research Centre - Jeddah (KFSHRC-J) was required and approval received in December 2004.

This ethnographic approach relied extensively on participant observation and involvement of participants in the co-construction of data

and findings, where the use of a formalised approach to obtaining individual written consent was not appropriate, nor often feasible. Discussions and observations occurred as part of the daily flow of working with nurses, participating in conferences and expert insiders asking about observations I had made during my project. People volunteered information as part of conversations from the knowledge that I was researching a topic of meaning for Arab Muslim nurses.

This is a form of “action consent” where the person “is informed about the research and begins to talk in relation to the research, thus consent is active or implied” (Fitzgerald, 2005, p 5). Where a discussion was related to my study and likely to be discussed in the thesis (such as the ethics case studies), I obtained verbal consent to use the information as part of my research. A Participant Information Sheet and Consent Form (see Appendix B) was used for all interviews (individual and group) that were tape recorded and transcribed for further analysis. Participants received a copy of the information sheet with the signed consent forms retained in secured research files.

When setting up the validation focus groups sessions, potential participants were told that the purpose was to discuss and validate the study findings. Participants came as they were interested in the project. At the beginning of each session, the validation process was explained and verbal consent obtained from the participants. These sessions were not tape recorded, but written notes were taken on key points during the discussion.

The process of consent in my study is consistent with ethnographic methodology. As explained by Fetterman (1989), ethnographers use formal and informal consent processes. The nature of the consent changes according to the context of the study and within the study according to the data collection method. As noted by Murphy and Dingwall (2001, p. 342), "In complex and mobile settings, it may simply be impractical to seek consent from everyone involved. Unlike experimental researchers, ethnographers typically have limited control over who enters their field of observation." In my study, I was immersed in the setting as a "complete-member researcher" (Angrosino & de Perez, 2000), which means that I was already a member of the study setting, rather than an outside observer. As such, various ways of obtaining consent were used when the interaction was purposeful for the research process (as described for the validation focus groups). In addition, presentation of data from interactions in this thesis preserves the anonymity of the participants (with noted exceptions) with a focus on the content rather than the source of the data.

Summary

The ethnographic approaches of Geertz (1973), Fitzgerald (1997) and Davies (1999) guided this study into the meaning of nurses' caring. The ethnographic approach of Geertz (1973) requires the development of thick description to describe and interpret a cultural phenomenon. Fitzgerald's multi-method (1997) approach to data generation and analysis supports the notion that ethnography is both an analytical

process and a product, where the research questions guided this process to achieve thick description by embedding the phenomenon within the cultural context. Drawing from the constructionist view that meaning is constructed as interpreted through an interactive process, the reflexive approach by Davies (1999) supports the co-construction of meaning by researcher and participants⁸.

Data generation focused on explicating the health beliefs used in the caring experience and the meaning of this caring as expressed by the nurses. Strategies for concurrent data generation and analysis included immersion into the experiences of the nurses, conference presentations, individual and group interviews, use of narratives and review of documents.

Data analyses encompassed multiple methods to interpret, re-interpret and construct theories of meaning. Initial data analysis focused on developing low level theoretical concepts and ethnographic moments were used for reflexive data generation and analysis. A deeper understanding of core related concepts developed and this is discussed in other chapters in some depth. Participants used narratives to convey cultural beliefs and caring experiences and these contributed to theoretical constructions. Analytical writing and development of conceptual diagrams took the analysis to a higher theoretical level. The

⁸ I have chosen to call the nurses “participants”, rather than the ethnographic term “informants” as I want to convey their active participation in all phases of the study. To me, the term informant fails to capture the interactive nature of the study and co-construction activity.

outcome of the data generation and analysis is found in the findings chapters: Explanatory Models of Health, Illness and Healing, The Meaning of Caring, Ethical Dimensions of Caring and Cultural Caring - Protection of Dignity.

The validation process used throughout this study included member checking and presentation of preliminary findings to different expert insiders and at conferences. An extensive validation process at the end of the study resulted in the development of what some may consider a model of caring that the participants co-created. Thus, through validation with the Arab Muslim nurses, this research demonstrates utility, credibility, validity and significance to the participants.

The four findings and subsequent discussion chapters explore the meaning of caring as embedded in the cultural world of the Arab Muslim nurses discovered through this interpretive, reflexive ethnographic approach. I now turn to the health and illness belief systems of these nurses as this provides important context for understanding their care meanings.

Chapter 4:

Explanatory Models of Health, Illness and Healing

Introduction

This chapter presents the health and illness beliefs of nurses within the context of Arab culture and the Muslim worldview. It provides a brief overview of the meaning-centred approach and key beliefs in Islam that draws on the extensive background provided in Chapter 2. I used multiple sources of data, including participant observation, individual and group interviews. I studied source information on Islamic teachings about health, illness and healing and these teachings are presented as both background and data. My interpretation of data from interviews and observation enabled the health and illness beliefs that shape the experience of Arab Muslim nurses' caring to emerge.

Explanatory models

I am interested in explanatory models (Kleinman, Eisenberg, & Good, 1978; Kleinman, 1980) as culturally based explanations concerning the concepts of disease, illness and healing. Good and Good's (1981) meaning-centred approach is an interpretive framework for exploring the symbols, values and conceptual forms of explanatory models. Disease has biological or psychological causes, while illness is the personal and social response to the disease experience. As noted by Good and Good (1981, p. 175): "Any illness may be conceived as a coherent syndrome of

meaning and experience that is linked to a society's deep semantic and value structure.”

Healing occurs as a transaction across popular, religious, folk and professional meaning systems and results from the construction of culturally specific realities and therapeutic efforts to transform these realities (Good & Good, 1981). Health and illness beliefs that influence behaviour include beliefs about the causes of disease, responses to illness, injury or disability, and other “culturally constituted health and illness related beliefs, behaviours and expectations, including help seeking and the use of alternative healing; and the roles for others (especially family members)” (Fitzgerald et al. 1997, p. 13).

Islam: The religion

Islam is both a religion and a complete way of life. Three beliefs are central to the religion: the concept of *tawheed*, a belief in predestination (*qader*, meaning God's will) and belief in life after death following the Day of Judgement. These beliefs are discussed in chapter 2 and highlighted here to provide explanation for the impact of Islam on the explanatory models used by Arab Muslim nurses.

Tawheed means the oneness of Allah and is the most important concept in the worldview of Islam. This unity of Allah derives from the belief that only Allah is ultimate, and Allah's unity must be maintained spiritually (morally), physically and emotionally (Rassool, 2004). The belief in predestination means that life unfolds according to Allah's will. However, Muslims can influence their destiny by good deeds and living

according to the teachings of Islam. Muslims believe in life after death, where they will stand before Allah on the Day of Judgement and face judgement according to their deeds on earth (Al-Shahri, 2002).

A blending of worldviews

There is a blending of worldviews in Arab Muslim nurses' explanatory models. Arab Muslim nurses consider that the scientific basis of nursing comes from the Western biomedical model while the values and beliefs about health and caring come from the Eastern view. This distinction arose early in the research, when Dr. Wafika Sulieman, a leader in Middle Eastern nursing, said to me: "I read about nursing from the West; I think about nursing from the East." This ethnographic moment was the first insight for me that Arab Muslim nurses had a distinct perspective on health and nursing. I used this comment to open discussion on what differences there were, if any, between Western nursing and nursing in the Middle East. An Arab Muslim nurse explained: "You learn the scientific thing from the Western view ... but when you deal with the patient, you have to deal as you are from the East. She means: emotionally, spiritually. Emotion, feeling, spiritual, religious, you have to do it because in our Holy Qur'an. It says how to deal with a Muslim person."

The literature suggests that the Muslim worldview is congruent with the holistic Eastern worldview that emphasises the whole human being. As explained by Rashidi and Rajaram (2001, p. 56), "care in the Islamic view is a reflection of the Eastern worldview that emphasizes the whole

human being and integrates and balances the spirit (*rouh*), body (*badan*) and emotion (*naphs*) [soul].”

In the Muslim worldview, Islam provides the basis for beliefs about health, disease, illness and healing. Islam requires a unity of Allah in physical, mental and moral (spiritual) aspects of life (the concept of *tawheed*). Rahman (1984, p. 585) explains how the Qur’an rejects the Western concept of mind-body dualism (from the philosophy of Descartes) and promotes the principle of the person as a unitary being:

The Koran⁹ does not accept a radical mind-body dualism in man. Although it speaks of an outer, physical and an inner, spiritual aspect of the human personality, the human person is not viewed as a composite of two separate or disparate substances which somehow come into an uneasy union in this life while the “spirit” longs to free itself from bond or bondage ... the Koran and orthodox Islam regard a human being as a unitary functioning organism; their view of afterlife is, therefore, not of the soul’s survival after bodily death but, rather, of God’s revival of the whole organism on the Day of Resurrection. In this life, health means the well-being of the whole organism, in body and mind.

Islam and health

Islamic jurisprudence provides *fiqh*, or practical Islamic rulings, on various aspects affecting the life of an individual, such as worship (*ibada*),

⁹ In this thesis, I use the spelling “Qur’an”; however, some quoted literature will use the alternative spelling “Koran”.

marriage (*nikah*), commercial transactions (*muamalat*) and prosecution (*aqdiah*) (Al-Khayat, 1997). There is no definitive *fiqh* or practical Islamic rulings on health, but various religious teachings, including the Qur'an, have references to health related aspects. Dr. Muhammad Al-Khayat (1997) attempted to examine the *fiqh* of health in a World Health Organization (Eastern Mediterranean Region) document titled: *Health, An Islamic Perspective*. Several Muslims (nurses, health educators, physicians) referred this document to me for my study.

In 1948, the World Health Organisation defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2002). Al-Khayat (1997) suggests that the Islamic view of health as complete physical, psychological, social and spiritual well-being is in accordance with the World Health Organization definition of health. However, the Islamic view of health adds the spiritual dimension absent from the worldview reflected in the WHO definition.

Health is a blessing from God

Muslims emphasise the importance of health as after faith, health is the second greatest blessing from God. There are two frequently quoted *hadiths* (sayings of the Prophet, PBUH) that support the belief of health as a great blessing. According to Al-Khayat (1997, p. 15),

The Prophet (PBUH) said: "There are two blessings which many people do not appreciate: health and leisure." He also said: "No blessing other than faith is better than well-being." As an aspect of

grace, man should express gratitude to God for health and it should be properly looked after.”

This appreciation of health is supported by another saying from the Prophet (PBUH): “He¹⁰ of you who finds himself enjoying good health, secure in his community, and has his daily sustenance, it is as if he had the whole world at his fingertip” (as cited in Hedayat & Pirzadeh, 2001, p. 968).

The Qur’an provides guidance on caring for health and maintaining the body. Muslims are required to maintain cleanliness and personal hygiene, eat healthy food, avoid forbidden substances that will harm the body, exercise and rest. This duty to care relates to the belief that human beings are the crown of creations and God’s vice regents on earth (Al-Khayat, 1997). Al-Khayat (1997, p. 12) describes the duty to care as:

The human body may rightfully claim from its owner to be fed when hungry, rested when tired, cleaned when it gets dirty, protected against harm and disease, treated when suffering from an illness, and not overburdened. This is a rightful claim which imposes a duty on every one of us. It must never be neglected or made subordinate to other rights and claims, including those belonging to God Himself.

Health is seen as a gift or reward from God and Muslims are accountable to God on the Day of Judgment for how they have taken care

¹⁰ All language in the Qur’an and *hadith* (sayings of the Prophet, PBUH) is gendered, and quoted as such throughout this thesis

of their health. The Prophet (PBUH) said: “No one will be allowed to move from his position on the Day of Judgment until he has been asked how he spent his life; how he used his knowledge; how he earned and spent his money; and in what pursuits he used his health” (as cited by Al-Khayat, 1997, p. 15).

Health as balance and health potential

The concept of health as balance is a theme that flowed through the data. Balance is an integral concept in Islam, as stated in the Qur’an (55:7-9)¹¹, “He raised it high and He has set up the Balance. In order that you may not transgress (due) balance. And observe the weight with equity and do not make the balance deficient.” The concept of balance and the link to living a satisfactory life in preparation for the Day of Judgment was present in the beliefs expressed about health by participants. A nursing teacher explained her view of health as more than the absence of disease; it also included the need for balance while living a satisfactory life:

Long ago health has been defined as an absence of disease or deformity, but no one is completely absent from something that blocks him, even if it is a minor problem. But health means I have a balance. I can balance my life without complication or complaints, not a whole absence of disease, like the definition of WHO a long

¹¹ The translated version of the Qur’an used for all quotes in this thesis is: Al-Hilali, M., & Khan, M. M. (1419 H (1998 G)). *The Noble Qur’an (English Translation of the Meanings and Commentary)*. Medina, K.S.A.: King Fahd Complex for the printing of the Holy Qur’an.

time ago when I was a student. It's the absence of a disease or deformity, and how you live a satisfactory life; how you can compensate your life and adjust to the situation. This means you are healthy.

One participant described the need to maintain a balance between the psychological or mental and physical aspects.

Psychologically you are healthy. Mentally, you are healthy. Physically, you are healthy. And you maintain a balance between the three of these essential requirements, or essential elements as a human being. I think this is the meaning of health for me because no one is completely absent of something ... that makes a little bit of discomfort.

The ideas of balance and harmony are in accordance with the Eastern worldview. Similar findings reflecting the concept of health as balance emerged in research by Daly (1995) and Emami et al. (2001). Daly (1995) asked participants: "What does being healthy mean to you?" in her study on the health meanings of Saudi nursing students. Their health meanings reflected a multidimensional view of health as more than absence of disease. Practicing healthy ways (health promotion), performance of roles and harmony within life were the top three categories. Daly (1995) explained that practicing healthy ways is consistent with the belief that a Muslim has a duty to care for the body. Emami et al.'s (2001) study on the meaning of health for Iranian (Muslim)

late-in-life immigrants in Sweden found that continuity in life, balance and spiritual unity underpinned beliefs about health.

Moawad (2006) addressed a range of health and spiritual dimensions in his writings on a “Code of Ethics for Islamic Nurses.” The concept of balance between the materialistic and the spiritual life to maintain health was a central theme. He noted that

We are made of two realms, the materialistic realm and the spiritual realm. Therefore, we must have a balance between both realms. In modern civilisation, we have given more emphasis to our materialistic needs and wants and we tend to neglect our spiritual needs and wants; creating by this a tremendous risks to our health and the world around us (Moawad, 2006, Conclusion ¶ 1).

Balance and health potential are part of maintaining health. Early Muslim scholars and physicians described health as a state of equilibrium as well as a state of the body. Disease is the opposite state of normal bodily functions (Al-Khayat, 1997). Maintaining balance in a state of equilibrium helps to develop health potential in the form of proper nutrition, good immunity, physical fitness or the ability to deal with stress. According to a *hadith*, the Prophet (PBUH) said to “store up enough health to be drawn on during your illness” (Al-Khayat, 1997, p. 13).

A nurse pointed out that health must not be just maintained, but continually improved or health will decline. She described health as a state of “general feeling of well being” and the “consistent striving to improve ... a general feeling of well being that is stagnant eventually will

start to degrade because people lose the striving for improvement. So, [health is] well being with a continuous look for opportunities to upgrade the feeling of well being or maintaining it.”

Disease, illness, healing and dying

Nurses' views on disease, illness, healing and death mirrored the Islamic teachings on health and disease and the belief in predestination. Illness, suffering and dying are all part of life and Muslims should receive illness and death with patience, meditation and prayer (Al-Shahri, 2002; Hedayat & Pirzadeh, 2001; Lovering, 2002; Rassool, 2004). Illness is viewed in different ways. It is considered a natural occurrence as well as a test of faith, opportunity for greater reward in the hereafter if accepted with patience, or as atonement for sins. Illness is not seen as a form of punishment from God or an expression of God's wrath, but as opportunity: the greater the illness, the greater the reward. The Prophet (PBUH) said,

Sickness and tribulation bring an opportunity to earn reward through patience and steadfastness and are a cause for cleansing one's sins ... No Muslim will be afflicted by hardship or illness, or anxiety or worry, or harm or sadness, even the pricking of a thorn, except that, by it, Allah will cover up some of his sins (Hadith as cited in Ahmed, 2008, p. 37).

Within this worldview, Allah predetermines disease and cure, however, a person should try to prevent disease or pursue treatment. Response to medical treatment is considered *qadar*, meaning,

preordained by God. Al-Khayat (1997, p. 9) summarises the guidance given by God:

A hadith quotes the Prophet (PBUH) as saying: “Every disease has a cure. If treatment is administered with the right cure, the patient will recover by God’s grace.” In a different version: “God has not created a disease without creating a cure for it, which may be known to some and unknown to others”.

Disease may benefit the person, as it may be Allah’s will for the person to rest or take care of their body. Disease may also enable a person to return to equilibrium in life and achieve greater knowledge of God. A classic Islamic scholar, Imam Al-Ghazzali, states that “illness is one of the forms of experience by which man [sic] arrives at knowledge of God” (as cited in Yousif, 2002, Significance for modern medicine ¶ 2). Pain from disease serves to remind the Muslim that there is punishment for those who do evil and they will go to hell in the hereafter. The ultimate in suffering, death, is part of the journey to meet Allah and a natural and inevitable phenomenon of life’s journey (Hedayat & Pirzadeh, 2001). The Qur’an teaches that it is Allah who gives life and causes death (Qur’an 3:156) and Allah who takes away the souls at death (Qur’an 39:42). The belief that illness, suffering and dying are all part of life and that a Muslim is to receive illness and death with patience, meditation and prayer was a continuous thread underpinning the caring role of the nurse.

Predestination

I came to recognise these beliefs expressed in everyday language about the health experience and seamlessness between Muslim values, health beliefs and the nurses' explanatory models. I began to understand these beliefs when talking to nurses about their patients and the way Muslim values informed their caring experience. For example, I talked to an oncology nurse about the emotional challenges faced when caring for dying patients. The nurse said to me, "It is God's will when they die, it is written. So, it is not so hard for us, as it is for the non-Muslim nurses. We know it is the patient's destiny." When a nurse would talk about a patient with a short time to live, the focus was on supporting the patient and family to accept God's will. Nurses frequently expressed this belief in predestination and it seemed to help them care for very sick patients. As noted previously, belief in predestination is one of the core values in Islam and a foundation for nurses' beliefs about health and illness.

A discussion about human destiny as predestined by God and the impact of this on the patient's acceptance of their health condition followed a conference presentation on "The Context for Caring in Middle Eastern Nursing" (Lovering, 2006a). One Western non-Muslim nurse expressed her view that the belief in predestination leads to dependency and "victimisation" of the patient (her words), which de-motivates patients to improve on their health. She believed that her (Saudi) patients seemed to "give up" as they did not feel in control. The Arab Muslim nurses rejected the idea that a belief in predestination may contribute to victimisation. They suggested that the symptoms of victimisation might

actually be symptoms of depression. They agreed that victimisation would occur if the patient did not have the ability to be with family and to pray, emphasising the connection of belief in God's intervention and plan for destiny.

The Western perception and comments of "victimisation" sparked a strong response from these Arab Muslim nurses, who explained that in Islam "your destiny is written by God, but we do not know what it is." However, personal actions impact on destiny as "you can prolong your destiny by doing good." Another nurse told the audience that "one *hadith* is saying that we should work as if we live forever, but live as if we would die tomorrow."

These nurses disputed that Muslim patients are passive recipients in their care, but instead, are active in their relationship with God and God's plan for them. A nurse explained to the audience, "Allah does not say surrender. He punishes gently. He created diseases and he also created cure." Another nurse stated, "Illness is not a punishment. It is God, when he loves you he gives you hardship, to make you suffer, so that it makes it easier to die."

In this same discussion, an intensive care nurse explained "even intubated patients pray for cure" even though her patients are bedridden and unable to move or talk. Another nurse stated that patients face their illnesses well and gave an example of her own sister "who kept her faith in God until the last minutes, and then they all prayed together for those last minutes."

Cultural beliefs: Evil eye and jinn

In the nurses' explanatory models, cultural beliefs exist along side medical and Islamic explanations for disease and illness. The belief in the evil eye as a cause for disease is an Arab cultural belief held by many Arab Muslim nurses. Belief in the evil eye as a supernatural cause of disease or misfortune is common to many cultures (Helman, 2001), including parts of Europe, the Middle East, and North Africa. Belief in the evil eye predates Islam (Spooner, 1970) and there is reference to the evil eye in the Qur'an (113:1-5), which places this belief within the spiritual realm mixed with cultural beliefs. The evil eye is cast, intentionally or not, by someone jealous of another person's fortune or beauty, or through admiration of others' possessions. Newborns, children, and pregnant women are more vulnerable to harm from the evil eye than adults and the elderly.

Protection from the evil eye comes from the words "*Masha'allah*" (what God has willed). For example, the admiring person will say "*Masha'allah*" when congratulating a new mother on her healthy baby. In many Middle Eastern cultures, blue beads or a blue stone such as lapis are worn as protection. To cure the evil eye, a religious person prescribes actions that will always include readings from the Qur'an and Islamic prayer formulas (Al-Jauziyah, 2003; Kendall, 1992; Lipson & Meleis, 1983; Luna, 1994; Lovering, 2002).

A nurse explained that the evil eye is part of Arab culture, although there are variations within the same country or across the various regions. He said that "the evil eye is real. You must say *Masha'allah* (Allah's

blessing) for a person that you admire.” At the time of this research, I was also undertaking a collaborative inquiry project in which a multicultural group explored cultural beliefs around the experience, causes and treatment of pain (Lovering, 2006b). In this project, a Saudi health educator told the story of her healthy younger sister who died suddenly one night, as a result of the evil eye. She explained that a visiting distant family member had admired her sister’s beauty, but did not say the blessing *Masha’alla* afterwards to protect her.

On another occasion, I was surprised when a Master’s qualified nursing instructor said, “Sandy, of course you believe in the evil eye!” during a group discussion on traditional beliefs and transcultural nursing. I came to understand the depth of this belief system during later validation focus groups discussions. A new graduate Saudi nurse expressed her difficulty in reconciling the belief in the evil eye as a cause of disease with the biomedical model she experienced in her practice. The rest of the group explained to her that disease is either from the evil eye, a test from God or from witchcraft. The biomedical causes for disease were incorporated into the overall belief that Allah determines your destiny, and the cause and treatment for disease remains as God’s will. Disease from the evil eye is according to God’s will as All Knowing. If the patient believes that their disease is from the evil eye, the nursing action is to ask a sheik (religious healer) to pray for the patient, which will dispel the evil eye.

Belief in the *jinn* is another form of blending religion with cultural beliefs. The Qur’an identifies *jinn* as good or bad spirits. The Qur’an

teaches that Allah created humans and the *jinn* to worship Him. According to Al-Hilali and Khan (1419, p. 871), *jinn* are “created by Allah from fire, like human beings from dust, and angels from light.” The *jinn* may cause abnormal physical or mental behaviour (Lovering, 2002). One nurse explained that “*shatan (devil)* is when the *jinn* go into the body, like a possession. The sheik will read the Qur’an and can diagnose the problem. It may or may not be the *shatan*, so the person may need to go to the doctor.” However, the cure for the *jinn* is always by a special religious healer who will read from the Qur’an and use psychology or other methods to get rid of the possession (Sebai, 1982).

The nurses said that there are mixed beliefs about the *jinn* among nurses and patients and told stories about the presence of the *jinn* in the hospital. “Many patients see the *jinn* as a hallucination. It is very scary for the patient and the nurse.” Some stories relate to unexplained occurrences after a patient has died. “It happened on the oncology floor, when a patient died and the next one admitted. He could not sleep as he had a “feeling”. We thought it was the *jinn*, so we brought in the sheik (religious advisor for the hospital) and he found the *jinn* in the room.” On another occasion, there was an admission to the paediatrics floor. “All the time the patient felt like the furniture was moving, and it was noisy from above. The nurse called the nursing unit above this room about the noise, and was told that the room was empty. It was a *jinn*.”

Religious healing methods

Muslims believe that repetition of verses (*ayas*) from the Qur'an support healing. Reading of verses from the Qur'an has been used as a direct source of healing since the beginning of Islam. A group of nursing faculty directed me to the book *Healing with the Medicine of the Prophet* (PBUH) by Imam Ibn Qayyim Al-Jauziyah (2003) to learn more about the use of various healing methods used by Muslims. One section on use of *ruqyah* (Islamic prayer) formulas and natural medications was particularly useful for understanding the use of specific prayers and verses from the Qur'an and *hadiths* for treating of pain and fever, curing the evil eye, treating scorpion stings and various wounds. During every day conversation, nurses told me that different supplications (religious sayings) are used during the care of patients. For example, there are specific supplications used during labour and birth of a baby, to assist in healing, protection of the patient's health and prior to giving medications.

Spiritual health and the "healthy heart"

The Qur'an is a book of healing (Yousif, 2002) as stated in the Qur'an (17:82), "And We send down of the Qur'an that which is a healing and a mercy to those who believe ..." Traditional Islamic teachings consider that there is physical and spiritual disease, with spiritual disease more serious (Ahmed, 2008). Muslims believe that Allah judges a person for the health of the inner being, meaning spiritual health. In the Qur'an, there is a focus on the causes and treatment of moral disease and spiritual healing (Ahmed, 2008; Kasule 2004). There are numerous

references to disease of the “heart” which leads to physical and mental ailments. These ills of the heart may be forgetting Allah or attachment to the material world (Al-Jauziyah, 2003). As noted by Kasule (2004), loss of spiritual equilibrium is a disease in itself and soon leads to inability to handle normal stresses of life and physical disease.

Ahmed (2008) explains the symbolism of a healthy heart for spiritual well being and health. He uses an etymological approach to examine the nature of health and illness within the Islamic worldview. A person has an external being, the *corpus*, which is similar to other creatures. The central point of a person’s inward being and the domain of the spirit and soul is the *qalb*, or human heart. *Qalb* is an Arabic term meaning the essence and inner most aspect of a thing.

The symbolism of the heart to emphasise the importance of spiritual health is found in many teachings of Islam. The link between the Day of Judgement and a sound heart as a symbol of spiritual health is found in the Qur’an (26:87-9): “And disgrace me not on the Day when (all the creatures) will be resurrected. The Day whereon neither wealth nor sons will avail; Except him who brings to Allah a clean heart [clean from *Shirk* (polytheism) and *Nifaq* (hypocrisy)].” The symbolism of spiritual health and the heart is stated as: “In their hearts is a disease (of doubt and hypocrisy) and Allah has increased their disease...” (Qur’an 2:10). The symbolism is repeated throughout the Qur’an, for example in the following verses: 5:52; 8:49; 9:125; 22:53; 24:50; 33:60; 33:32; 47:20; 47:29. The teachings of the Prophet (PBUH) link the heart to spiritual health, implying physical health, “Allah does not look to your bodies nor

your forms, but rather He looks to your hearts” (as cited in Ahmed, 2008, p.36) and “There is in the body a piece of flesh, and if it is good the entire body is good. However, if it is diseased, the entire body is diseased; and know, it is the heart” (as cited in Ahmed, 2008, p. 36).

The symbolism that a healthy heart is the foundation for spiritual and physical well being also emerged from MacPhee’s (2003) anthropological study of Saharan housewives in southeast Sahara Morocco. She found that Islam provided a moral and cosmological context for everyday life. Islamic values shaped a “religiously informed concept of health” (MacPhee, 2003, p. 55) while the heart is seen as an organ and symbol that links spiritual, emotional and physical experience. Similarly in Good’s (1977) study of Saharan Moroccan Muslims, emotional distress was described as sickness of the heart.

Care pattern: Spiritual needs before physical needs

In order to understand Arab Muslim nurses’ explanatory models, it is important to not only understand the source of their models (one of them being their religion), but how this information gets translated into, or integrated into, their notions of caring. As humans are judged on the health of their inner being (spirit) and spiritual disease could lead to physical disease, it follows that meeting spiritual needs may have priority over physical needs. The importance of meeting spiritual needs before physical needs is a significant care pattern and is central to the nurses’ explanatory model.

An Omani nurse identified the notion of spirituality as central to nurses' caring patterns. She said, "Spirituality is the centre of the relationship with Allah." In discussing the idea of spiritual needs before physical needs, she explained, "This is the beginning place, before the physical needs. When I have pain, I first go to Allah and ask forgiveness for what I have done wrong." She also emphasised the "need for harmony and balance as the basis for health."

Spiritual before physical needs: Confirmation by a reflexive process

This insight of "spiritual before physical" was an ethnographic moment, and the concept required further exploration with nurses as part of the reflexive ethnographic process. At the time, this concept jelled with my other reading on the importance of spiritual health in Islam. The "*spiritual needs come before the physical needs*" idea first came from a website site on Islam and health (<http://www.crescentlife.com>). It argued that Maslow's hierarchy of human needs requires redefinition.

The nature of man and hierarchy of needs should begin with his spiritual aspect and lastly his physical needs. The well-being of his life-force or soul-force or the vital-force that encompasses his life while he is on this earth is most important. Islamic holistic hierarchy is exactly opposite with the Maslow theory because the needs of the spiritual aspect come first and foremost (Integrative Paradigm of Islamic Holistic Medicine: Holistic Science – A new definition ¶ 23).

Taking this concept into the practical world of nursing, I tested this idea on numerous occasions during individual and group discussions and conference presentations with both Arab Muslim and non-Muslim nurses. The majority of Arab Muslim nurses confirmed that spiritual needs may have priority before physical or technical nursing requirements, and shared many narratives to demonstrate this idea. This idea also made sense for non-Arab, non-Muslim nurses, as it explained why their Arab Muslim patients delayed “professional” caring for spiritual actions, which was a source of distress and cultural misunderstandings for non-Muslim nurses. My deeper understanding of the need to meet spiritual needs before physical needs evolved into a more comprehensive appreciation of the centrality of spirituality in caring by Arab Muslim nurses, as I discuss in the following chapters.

The first time I tested this idea of spiritual before physical needs was over a cup of coffee at a nursing conference, just after I had presented a paper on “The View of Nursing through a Cultural Lens” (Lovering, 2005a). I was talking to a Western nursing instructor, who was teaching Saudi diploma nurses in a school of nursing. We were discussing my study, and I told her that I had an “aha” about the need to turn Maslow’s hierarchy of needs model upside down when looking at caring by Muslim nurses. She told me her story as an example of putting spiritual before physical needs when teaching Maslow’s model to first year nursing students.

To make the point that physical needs are the first consideration under Maslow’s hierarchy of needs, she asked the students what

they were most concerned about when they came to the first day of class. She expected they would say, where can I eat, will I be comfortable, what to wear, where do I go. To her surprise, 75% of students said that they were worried about interacting with a Western woman. She interpreted this as being from their cultural and spiritual concerns, as she was of a different religion and culture, that is, they were concerned with meeting their spiritual needs first. (Field notes, 1 March 2005).

Later in the day, there was a discussion on the impact of cultural values and nursing. The nursing instructor told the audience: "Sandy said something provocative during the break time, that Maslow's hierarchy was not applicable, as spiritual needs come before physical needs." I discussed the article and my observations that spirituality comes before physical in the religion. A Malaysian Muslim nursing school instructor and several Saudi nursing students emphatically nodded their heads in agreement. A Saudi nurse said to the audience, "Yes, you must meet the spiritual before the physical."

During a further discussion at the same conference, the need for prayer when preparing the patient to go to the operating room was highlighted as an example of meeting the spiritual needs (prayer) before the physical needs (operation). The Saudi nurses were adamant that the patient must be allowed to pray, even though it delayed surgery. "It was imperative that the patient prayed before going to the operating room, this was above everything else." One solution was to say to the patient: "You

will be going to the operating room in 30 minutes, would you like to pray now?”

A Bahraini Muslim nurse shared a similar example when discussing the concept of spiritual needs having priority over physical needs. The nurse worked in the recovery room and before transferring the patient into the operating room, she would ask the patient if she (the patient) wanted her (the nurse) to pray for her, or if the patient wished to pray. She considered this action as part of the pre-operative preparation. This nurse explained the difference between meeting the spiritual needs of the patient as part of caring and the more generic need to pray. She explained that it is acceptable to delay the operation to enable the patient to pray. In contrast, the porter would perform his obligatory prayers after the patient care is done.

On another occasion, there was a conversation with two Western nursing educators (one Christian, the other Muslim) about spirituality in nursing. This conversation followed their participation in a group discussion with Arab Muslim nurses about the place of spirituality in Islamic nursing. Our conversation centred on spirituality being missing from the physical and psychosocial well being when caring for the patient in the West. We agreed that the spirit is an “add on,” not a starting point, noting that “for Muslim nurses, the ice cream cone is upside down, with the spirit at the beginning, whereas in Western nursing, it is the chocolate topping after everything else.”

The importance of meeting spiritual needs as well as physical needs as part of the provision of patient care by nurses and doctors was

highlighted to me when I worked at an ophthalmology hospital in Saudi Arabia. In the paediatric ophthalmology unit, nurses cared for families whose children needed to have enucleation (removal of the eye) for retinoblastoma (cancer of the retina). It is usual that the family do not wish to give consent for an enucleation and may choose to seek support from the *sheik* (religious healer). In this situation, the medical doctor and religious healer meet spiritual and physical needs jointly. To meet the important spiritual needs while getting support for the physical intervention, the Saudi paediatric physicians use a story to assist a family facing the decision to consent to enucleate their child's eye to save the life.

“Your child is drowning in a river. On the riverbank are two people who can help — a sheik who can read the Qur'an, and the other is a strong swimmer. Who would you choose to save your child?”

Most parents chose the strong swimmer. The doctor says, “I am the strong swimmer. Let me take out the eye and save the child. You still need the sheik to read the Qur'an, and to pray for your child. Together, we will keep your child safe.” (Lovering, 2002, p. 21)

Spiritual before physical needs: A unique care pattern

The care pattern of placing spiritual before physical needs is not explicitly documented elsewhere in the nursing literature. Literature on care patterns and nurse caring within the Eastern philosophies, such as Chinese, reflect the need to support restoration of balance and harmony

(Chen, 2001; Pang et al. 2004; Wong & Pang, 2000; Wong et al., 2003).

Korean nursing care patterns include the spiritual dimension when seeking to restore the balance of the *yin* and *yang*, strengthening the patient's *chung* (physical materials that make up the body), *khi* (energy that maintains the life, physical and mental activities) and *shin* (spirit or soul) (Shin, 2001).

There are similarities and differences in care patterns between Arab Muslim and Native American nurses. Similar to Muslim beliefs, the concept of balance in health for Native Americans consists of spiritual, mental, emotional and physical aspects (Hunter, Logan, Goulet & Barton, 2006). Spirituality is one of seven themes determined to be the essence of Native American nursing, but not core to the belief system. The seven themes, in order of significance, are: caring, traditions, respect, connection, holism, trust and spirituality. Spirituality is a "natural basic element of their being and, therefore, a real part of life" (Struthers & Littlejohn, 1999, p. 134), but is not placed as priority over physical or mental needs.

In most Western nursing models, spiritual needs are neglected or incorporated as part of a greater holistic approach, as explored more extensively in chapter 9, Caring: Shared Meanings and Spirituality. Watson's (1988b) human caring theory for nursing touches on the spiritual aspects of the transpersonal interaction from a metaphysical perspective, but spirituality is not at the core of the caring pattern. Placing of spiritual before the physical needs is not present in any contemporary nursing models.

Summary

This chapter describes the health explanatory model of Arab Muslim nurses within the context of Islam and Arab culture. The Islamic religion is core to the Arab Muslim belief system and guides all aspects of the individual's life and society views. The impact of Islam on shaping the nurses' explanatory model is expected and Islamic perspectives of health, disease, illness and healing must be integral to the nurses' belief system and that shared with the patient.

Within the Muslim worldview, health is a gift or reward from God and encompasses complete spiritual, physical and psychological well being. Balance and equilibrium contribute to creating health potential to cope with disease and illness. God predestines disease and cure. The illness experience has religious meaning, as it may be a test of faith, opportunity for reward, atonement for sins or to gain greater knowledge of God. The belief in predestination was the basis of the Arab Muslim nurse's beliefs about health, disease and healing tempered by the ability to influence destiny through prayer, good works and relationship with God.

In Islamic teachings, a healthy heart is a symbol of spiritual well being. Through this metaphor, a healthy heart means spiritual health; spiritual well being is essential to achieving health. This symbolism implies the importance of spiritual over physical well being while the care pattern of placing spiritual over physical needs is in accordance with the belief. The following chapter describes the caring patterns that support the

spiritual and physical health of the patient, and caring emerges as an act of spirituality.

Chapter 5: The Meaning of Caring

Introduction

This chapter presents the caring patterns that support the spiritual and physical health of the patient as derived from the Muslim worldview. A shared worldview is the foundation of the relationship between the nurse and patient. As noted by Mebrouk (2004, p. 73), "Islam provides their framework upon which they base their scientific based nursing care and moral considerations involved in their decision making." Thus, caring and religion are inseparable for Arab Muslim nurses.

Caring as a spiritual action becomes the focus of this chapter. The narrative of the first nurse in Islam, Rufaidah, reveals aspects of the meaning of caring for Muslim nurses that continue to be relevant today. Rufaidah symbolises the acceptance of nursing within the religion, giving legitimacy to the caring role. The meaning of caring begins with the nurses' relationship with God. The nurses' caring actions assist or facilitate the patient's belief in and relationship with God and are grounded in the teachings of the religion. In caring for the patient, the nurse will get reward from God in the hereafter.

"Nursing comes from the Prophet"

In the Middle East, the history of nursing in Islam contributes to the nursing identity and shapes the caring role. As explained by one nurse, "nursing comes from our Prophet Mohammed (PBUH) so we have to be careful when we touch the patient and how we will deal with the patient."

When I was researching the career choices and experiences of Saudi nurse leaders in 1996, I found that the recognition of Islamic nursing history and development of an Islamic nursing identity were a recent phenomenon in the Middle East (Lovering, 1996). The history of nursing in Islam is now part of the nurses' training and nursing discourse in the Middle East.

In Saudi Arabia, the development of Islamic nursing identity and recognition of Islamic nursing history began in the early 1980s, when a small group of Bachelor of Science in Nursing graduates wanted to establish a professional identity for nursing in their country. They looked to the values of Islam as the basis for nursing in order to gain legitimacy and acceptance of nursing by the society. During my earlier study (Lovering, 1996), a nurse explained to me how this evolution happened.

When we were students ... we just listened to what was being said ... but after graduation ... after we had some experience ... we had to face the community ... and when you need to find things to convince them ... you have to find something on what you both believe ... to establish the base ... you have to go to Islam ... and we asked ... does it support nursing? ... and that is how we discovered that the Prophet made a place inside the mosque ... and he said clearly that if a woman nurses a male ... she had the right to see his private parts ... In the newspapers there were a lot of attacks from the religious people against us ... they say we are looking for the liberal woman ... so in order to counteract the

movement ... we go into depth to the Islamic nursing history (Lovering, 1996, p. 51).

During my current study, a group of Saudi nurses discussed recent developments in the nursing profession and the impact of this recognition of Islamic nursing history on their nursing identity. One nurse stated: "the work of the earlier nurses who went to the Qur'an (and *Hadith*) was a turning point for nursing in Saudi Arabia, to find that the Prophet (PBUH) supported nurses very strongly." Another noted that "the religion supports nurses in Islam, yet the culture does not."

The first resource on Islamic nursing history in English to be available in the Middle East was "Nursing in the Islamic Era" in Muneera Al-Osimy's (1994) book *Nursing in Saudi Arabia*. Al-Osimy (2004, p. vi) then compiled various papers on Islamic nursing history in a book, *The First Nurse*, where the aim was to:

Increase the information available in English about the true beginnings of nursing. We will not only be giving tribute to the real pioneers, we are hopeful we will inspire more support (on a global basis) and attract more a successful attitude towards nursing education in the Arab world. We encourage all interested individuals to write more and more and to teach Islamic Nursing History in colleges and institutes of nursing all over the Islamic World. This is a very vital part of medical history. We ask God for this reward.

When I searched the Western nursing literature, I was disappointed to find few publications on the history of nursing in Islam, with the exception of Jan (1996), Kasule (1998) and Miller-Rosser, Chapman and Francis (2006). A recently published book, *Women in Nursing in Islamic Societies* (Bryant, 2003) mentions Islamic nursing history in two paragraphs in the introduction, while giving two pages on the history of nursing in Europe. While the published literature is sparse, Islamic nursing history is taught in nursing curricula in the region, discussed at nursing conferences and in the public arena. One nurse explained that “in Nursing 101 they presented what is nursing and they started with the Prophet Mohammed (PBUH).” Another commented, “We know that they are first ones to do nursing in Islam at that time.” In the public domain, a Saudi newspaper article on working women in Saudi Arabia quotes Taqwa Omar, a Saudi PhD nurse on Islamic nursing history:

Omar said that during her studies, there were numerous references to the renowned British nurse Florence Nightingale, the “Lady with the Lamp” of the Crimean War of the 19th century. But, Omar says, Saudis can revel in their own model — Rufaidah bint Kaab¹² (God be pleased with her) — who was given a special medical treatment tent near the Madinah mosque by the Prophet Mohammad (peace be upon him). (Mubarak, 2006)

Knowledge of Islamic nursing history enables nurses to separate religious teaching about nursing from Arab social values that perceive

¹² Rufaidah is also referred to as Rufaidah bint Kaab, or Rufaidah Al-Asalmiya

nursing as morally corrupting of women (Lovering 1996). Most important, Islam gives acceptance to nursing. As noted by a participant in my previous research, “If Islam does not accept nursing, then how can I choose nursing as a career?” (Lovering, 1996, p. 30).

The story of Rufaidah Al-Asalmiya

Rufaidah Al-Asalmiya practiced as a nurse during the holy wars when the Prophet Mohammad (PBUH) established Islam in the 7th century (CE). Rufaidah set up the first school of nursing, developed the first code of nursing ethics and was an advocate for health education and preventative care (Jan, 1996). In this period of Islam, the female nurse was called *Al-Assiyah* from the verb *assaa*, which means curing the wounds. The Islamic verb *qaama*, which means to take care of patients, referred to both male and female nurses (Al-Osimy, 1994).

The narrative of Rufaidah as told from various perspectives (Al-Osimy, 1994, 2004; Hussain, 2004; Jaleesah, 2004; Jan, 1996; Karaha, 2004, Kasule, 1998) shows aspects about caring that continue as a thread in Islamic nursing today. Rufaidah’s narrative is presented and interpreted according to the themes: nursing as a means to practice Islam, acceptance of nursing in Islam, legitimisation of nursing and foundation of the nurses’ professional identity, and attributes of the ideal Muslim nurse.

Nursing as a means to practice Islam

Rufaidah was the daughter of Saad Al-Asalmi, a healer in Yathrib (modern day Medinah in Saudi Arabia). She assisted her father and

developed her nursing skills before she became Muslim (Jan, 1996). At the time of her conversion, there were many wars fought by the Prophet Mohammad (PBUH) to establish Islam as a religion in the area of Yathrib. When there was a call for support in the holy wars, Rufaidah saw nursing as a means to express her faith and commitment to the Prophet Mohammad (PBUH) and organised a group of women to assist in the wars in a nursing role. Hussain (2004, p. 17) tells the story:

Saad Al Aslami was a priest healer for his community, he claimed that he could cure illness by the secrets of the goddess, he used all kinds of tricks and deceived people in order to make them pay him precious gifts, and he was well known for his skills in medical treatment in the Arabian Peninsula.

Rufaida Al Aslamia¹³ — his daughter rejected her father's greediness and tricks, she had no faith in his incapable gods, and she was longing for pure sources of faith. Rufaida started teaching some of her friends about nursing and taking care of the wounded. Doing this, she was the first to establish an Arabic-Islamic School for Nursing.

Later when Prophet Mohammad (PBUH) declared (Jihad) a religious war, Rufaida asked permission to participate with her mates in serving the army, so they prepared all equipments needed for nursing the injured fighters and were with them

¹³ Again, the spelling of the Arabic names, such as Al-Aslamiya vary according to translations

supporting their struggle. During the Badr invasion, the first war in Islam, January, 624 G¹⁴, Rifaida and her mates helped by providing the Muslim army with water for the warriors and dressed the wounds of the injured until victory was achieved.

They came back to Madinah with the conquerors, and there Rifaida camped her tent by request of the Prophet Mohammad (PBUH) in his mosque which became the first Islamic clinic for medication [medicine] and nursing, Rifaida continued dedicating her efforts and time for public service. She was able to stop abusing of the patients by priest healers and her work was purely for the service of God.

Symbolism of acceptance of nursing in Islam

Nurses caring for patients in the mosque symbolises acceptance of nursing within Islam. Rifaidah also used the mosque to deliver health education to the community (Al-Osimy, 1994). Karaha (2004, p. 31) links the importance of nursing in the mosque with being an angel of mercy, a high recognition in the religion. She explains, “Koaiba [Rifaidah] established the first nursing clinic in the prophets’ Masjed [mosque]; she made a tent for treatment where all the sick can visit anytime they needed. By this way Koaiba [Rifaidah] was the first angel who gave mercy and love in Yathreb [Madinah].”

¹⁴ Meaning Gregorian calendar. The Gregorian calendar dates are synonymous with CE (Christian Era).

An important part of Rufaidah's narrative is the recognition given to the early nurses who participated in the holy wars. As noted by one nurse during the discussion groups, "nursing is well supported by the Prophet Mohammad, as nurses were recognised by sharing in the war booty."

Karaha (2004, p. 35) explains:

Every Mojahed [warrior] took his share; the prophet gave Koaiba [Rufaidah] her share just like the men because she worked during the war herself with full heart and feelings even more than many men. Koaiba [Rufaidah] was very satisfied and thankful for her share; she had more self-confidence, her belief in God and in her abilities and the abilities of the women to work during Jihad [Jihad] had increased. This great religion gives equal rights for male and females.

The symbolism of sharing equally in the war booty gives the message that nursing is worthy in Islam and raises the status of women in the nursing role. Al-Osimy (1994, p. 18) states: "The status of the women participating as nurses in the wars were so highly honoured by the Holy Prophet (PBUH) that he considered their effort as a form of *Jihad* in the cause of Allah. He used to give them their share of the war loots just [as] he gave men theirs." *Jihad* is described as a "holy fighting in the cause of Allah or any other kind of effort to make Allah's Word (i.e. Islam) superior. Jihad is regarded as one of the fundamentals of Islam" (Al-Hilali & Khan, 1419, p. 871).

The narrative of Rufaidah links nursing, the teachings of Islam and reward from God. The theme of nurses receiving reward from God for caring featured prominently in this study and is discussed more fully later in this chapter. Hussain (2004, p. 19) explains:

Back in Madinah Rufaida continued nursing in a mosque improving her skills and laid it basics using the experience she had acquainted [acquired] therefore we consider her the first to establish the technological roots for nursing, guided by the teachings of Islam and serving God, expecting no reward but from God.

Legitimisation of nursing and nursing identity

In my earlier research (Lovering 1996) I drew a correlation between the legitimisation of nursing in the Middle East through Islam and the transformation of Western nursing. There were similar views about the conduct and morality of women in the Victorian era as found in the Middle East today. At the time of Florence Nightingale, nursing gained legitimacy through linking nursing with a religious calling, a high moral ground, as a mission to serve mankind and an emphasis on nurses' special womanliness (Brodie, 1994; Nelson, 2001). Nursing became an acceptable career for women rather than a domestic role carried out by women of questionable morality. Jaleesa (2004) draws similar parallels in Western and Islamic nursing history. "Nursing holds at its core a tradition of caring and responsibility at great personal sacrifice. We have in our collective history stories of nuns caring for the poor, infirm and outcast.

Our rich history in Islam gives a reason for pride and a radical tradition to which we must set our sights.”

The importance of Rufaidah as the first nurse in Islam is the foundation of the nursing identity for Muslim nurses. As Jan (1996, p. 268) explains:

Because of Rufaidah we realise that nursing is a noble career for Muslim women in accordance to Islamic tradition. Indeed, Rufaidah is a great role model for us today. We who are Muslims should not forget our historical tradition and the example of Rufaidah — our first nurse, nurse educator, nurse leader, and founder of our first nursing school and clinics.

Attributes of the ideal Muslim nurse

Rufaidah is a role model for the Muslim nurse in the caring role. Jan (1996, p. 267) described Rufaidah as “very patient, kind, devoted, and committed.” Jaleesa (2004) noted that “Rufaidah had a kind and empathetic personality that soothed the patients in addition to the medical care that she provided. The human touch is a very important aspect of nursing that is unfortunately being forgotten.” Rufaidah’s contribution was not confined to nursing the injured, but extended to social work in the community and assisting all needy Muslims, including orphans and the handicapped. Kasule (1998 ¶ 1) states:

Her history illustrates all the attributes expected of a good nurse. She was kind and empathetic. She was a capable leader and organiser able to mobilise and get others to produce good work.

She had clinical skills that she shared with the other nurses whom she trained and worked with. She did not confine her nursing to the clinical situation. She went out to the community and tried to solve the social problems that lead to disease. She was a public health nurse and a social worker. Rufaidah is an inspiration for the nursing profession in the Muslim world.

Hussain (2004, p. 19) concludes the story of Rufaidah by noting, “In fact Rufaidah was the mother of human medication [medicine] and nursing in the world 14 hundred years ago ... Centuries later Florence Nightingale followed the steps of Rufaidah.”

The relationship between the nurse and God

The relationship between the nurse and God is the starting point for the caring experience. Similar to the example of Rufaidah, nurses practice through their faith in God. This faith is the basis of their commitment to nursing and shapes the nature of their relationship with their patients with whom they share the same values. As noted by Mebrouk (2004, p. 58), “Nurses (all Muslims) enter a relationship with their patients based on shared humanity including religion.”

The nursing pledge spoken by graduates of the Dar Al Hekma College School of Nursing illustrates the centrality of faith in the nurses' commitment to the profession. The Dar Al Hekma College School of Nursing in Jeddah, Saudi Arabia, graduated its first Bachelor of Science Nursing class in 2006. The nursing students and faculty, drawing from pledges of other Middle Eastern nursing colleges and the Nightingale

pledge, wrote the nursing pledge for this class. The beginning point of this nursing pledge is the relationship of the nurse with God as the basis of the nurse's commitment to nursing.

In the name of Allah, the Almighty, Who granted me wisdom as a means in life; Whose name is high and holy, who endowed on Himself the name and description of mercy; I pledge to be faithful to my religion, king, and nation; To offer myself to this profession through my faith in God (Dar Al Hekma College School of Nursing graduation ceremony, June 2006).

The relationship between the nurse and God was a central theme at a keynote address on "Morals and Practices of the Muslim nurse" at the 3rd International Nursing Conference in Muscat, Oman (Al-Osimy, 2005). Muneera Al-Osimy, Director of Nursing for the Ministry of Health in Saudi Arabia, described the duties of the Muslim nurse as: duty to God, duty of the Muslim to himself, duty of Muslim nurses to increase knowledge of science and nursing and the need to connect to the past and present (Al-Osimy, 2005). She encouraged Muslim nurses to be faithful, "pray as it leads to self instruction and inner peace," "work hard," and "seek God's forgiveness and satisfaction" as "God looks into your heart." Nurses should "be afraid of God and be faithful to God." Al-Osimy linked worship of God to the nursing role and the society's benefit.

Another keynote speaker at the same conference, Mr. Khalfan Mohammed Al-Esry, addressed the issue of "Ethics and Spiritualism in Islam." Al-Esry described nursing as a honourable profession "for nurses

have been entrusted with the most noble of all causes, and that is none other than providing comprehensive health care to the best of creatures, the agent of Allah on this earth, the human being” (excerpt from abstract, Al-Esry, 2005). Similar to Al-Osimy, Al-Esry (2005) linked nursing to the act of worship and gave direction for nurses to base their care on religious teachings.

The Qur’an gives a framework for how to lead life and to be effective in life. Man is made of two components: the body (physical life) and the soul (“ruh”), which is the most important part. The two of these combined is the essence of life. In the profession of nursing, the technology looks after the body, it is often forgotten to take care of the spirit. Nurses should look to the Qur’an and the teachings of the Prophet for guidance.

Teachings from the Qur’an emphasise the importance of the integrity of the nurse and her relationship with God. As explained by Moawad (2006, Organs transplantation ethics in Islam ¶ 5):

Nurses in Islam must have the fear of The Lord in their hearts so no harm is done by them to any of their patients whether they are monitored or not. They must believe that The Lord is monitoring them at all times when nursing patients and they will bear their neglect and their bad ethics towards their patients. In the same way they will be also rewarded by The Lord when doing the right thing. The Lord says in Qur'an; "Allah knows the fraud of the eyes

and all that the breasts conceal" (40:19) and "Your Lord knows best what is in your inner-selves" (17:25).

Nurses acknowledge their relationship with God as the beginning point of caring for the patient. In explaining this to me, a nurse differentiated between the theory of nursing she was taught and the impact of her faith on her caring action. She said, "But sometimes, Sandy, sometimes we are not practicing theory, we have the [nursing] books and the Qur'an. Sometimes we are not working by the [nursing] books, but by the spirit of God. Not by the books at all.

Caring action: Assist the patient's belief in God

Sharing the Muslim faith with their patients underpins the nurses' caring actions. The focus of caring is to assist the patient's belief in and relationship with God. One nurse summarised the focus of her caring as "building a relationship between the human [patient] and God," which is about the nurse being an agent or facilitator of the faith.

In Al-Osimy's (2005) presentation in Oman, the role of the nurse as a facilitator of the faith was emphasised. She encouraged nurses to mention God and remind others to mention God at all times. She linked the giving of advice for health to the act of prayer, "religion is advice, giving advice is like a prayer, and advice is the core of the religion." She advised Muslim nurses to remember and give thanks to God and to remind patients of the greatness of God. According to Al-Osimy (2005), the role of the nurse is to console the patient and "to remind the patient that the Prophet said everything is good for Muslims, including fever." If

having trouble with a patient, “it is the duty of the nurse to forgive and forget the bad words from the patient. Take God’s word and find a suitable solution.”

Similar beliefs guide the education of nurses. Al-Osimy (2005) noted that nursing “education is a part of prayer. It is important that faculty are believers [of Islam] and experienced in education. Teachers are like prophets on earth. The training of nurses must be within an Islamic environment, depending on Islamic principles and ethics.”

Al-Esry (2005), in his address at the Oman conference, linked the nurses’ own relationship with God and facilitating the relationship between the patient and God with the nurse’s integrity and competence when caring for vulnerable patients.

The first characteristic for nurses is to build a strong relationship between the human and God. Therefore, it is a privilege to have access to the guidance of God and to give you self control. There is no better standard than to be self guided (that is guided from God). When the patient is in front of you, they are vulnerable and rely on competence, professionalism and the humanity (of the nurse) to take care of him. Nursing is not about wearing dresses, caring for the sick, a social cause or invading privacy. It is about your integrity, pride, and professionalism.

Caring action as the facilitation of the faith is threaded through the narratives of the nurses in this research. One nurse explained the way

she responds to a patient who asks her to do something that is against the religion and her role as a nurse.

Sometimes the patient will ask you something that is not acceptable. You can't do it as a nurse, but if you say no to him directly, there will be trouble for you and the patient. You can say no to him in a nice way that respects his feelings. Give him the view from the religion and he will accept it very easily. He will be happy and feel that you are not checking up on him, or doing your job because you have to. You are doing it to take care of him, like he is your brother, or your son or your father.

Another nurse explained: "Sometimes we have arguments with the patients, but when we put the view of the God himself and the religion, it helps. Now they have the whole picture, and then have more respect for the nurses."

The concept of building the patient's trust in God was emphasised to me early in this study. I was attending an international nurses' day celebration as a speaker. There was a presentation called: "Breaking the News," by a paediatrician about caring for parents following the birth of a disabled child (Soby, 2004). These field notes describe key points in the presentation and the interactions that followed:

Dr. Soby first talked about planning a trip to Italy and the disappointment he experienced when he went to Holland instead. The point of his story was that a parent (the mother) goes through a pregnancy with dreams of the child and their future. When a baby

is born with disability, that dream is shattered, and there is a need to break the news about the baby in a certain way. He started his advice on breaking the news by talking about the importance of belief in God, which is “the most important thing.” You must present the baby as a gift from God. Secondly, the mother’s belief in God may be harmed. The mother often thinks that they did something bad, not just in pregnancy, but in her life, and that this disabled baby is punishment from God. “Why did God do this, God is punishing me?”, and this in turn affects their belief in God. Therefore, you must focus on the beliefs in God, and fixing the notion that they are being punished. “It is very important, as belief in God is the most important thing to the human being.”

During the question session later, I asked Dr. Soby: “How do you help the mother who believes that she is being punished, as this is a fundamental religious belief, that God will punish a person who does something wrong?” He replied that you focus on the facts. Down’s syndrome occurs in 10%¹⁵ of births in Saudi Arabia, there was nothing that the mother would have done to cause the disability. You talk about the facts. He said, “The most important thing is to build up their trust in God, give facts so it is clear it is not their fault. Believing in God is very important, use support group

¹⁵ I cannot verify that 10% of births in Saudi Arabia are Down’s syndrome through research findings, only that this is what Dr. Soby commented.

mothers and the community to help build this support and trust in God.” (Field notes, 9 May 2004)

Many nurses shared examples of the integration of their shared faith into the care of patients through the use of religious teaching, religious words and reinforcing the patient’s belief in God. A nurse explained to me how she calms a patient who is frightened of having surgery by supporting the patient’s belief in God, as the outcome is already predestined.

When they are scared about their surgery they come to us and say, “Sister we are scared to have this surgery.” There are religious words we can say like *Insha’allah*, if you believe in God, everything will be okay. You know you need to give some religious words to him because what will happen to him, it will happen. It [destiny] is written so that’s why we say you have to believe in God. Of course everything fine will come to you.

Another nurse explained how she assists the patient to read the Qur’an to relax the patient and reinforce the patient’s belief in God. She tells the patient to “read the Qur’an like this, to feel inside comfortable and satisfied. If you do, you will believe in God. Then you will believe everything will come from above. Even if he’s scared or not scared, he will be more relaxed.” An intensive care nurse used tape recordings of the Qur’an to calm her patients. She “went around with earphones to ICU patients and put on tapes with the Qur’an.” Nurses also linked religious teachings from the Qur’an to patient teaching.

The use of prayers and reading of the Qur'an were common caring actions in Mebrouk's (2004) study on Saudi nurses' caring. One nurse encouraged palliative care patients to receive comfort from listening to recitations of the holy Qur'an or watching Islamic lessons on the television. Another explained that when she "gives him the antiemetic and I am here beside him and I am reading the holy Qur'an for him, so it will make it much different, because we all believe in the Qur'an and the role of it, the spiritual feeling" (Mebrouk, 2004, p. 59).

In the same study, a nurse linked the emphasis given by the Prophet on cleanliness as a reason to clean the patient's skin prior to an injection (Mebrouk, 2004, p. 58) and use of *Zam Zam* water (holy water from Mecca) instead of regular water to give oral medications. A nurse in my study discussed the use of Zam Zam water as part of her spiritual care. She explained, "In the neonatal intensive care unit (NICU), the father will give you Zam Zam water to feed to the NICU baby. You may only give the baby a drop, or wash their face with it, or bathe the baby. This is spiritual care. The non-Muslim nurse does not understand how important this is to do."

Another nurse spoke of the importance of prayer and saying the *Ash-Shahadah* when a patient is dying. The *Ash-Shahadah* is the basic creed of Islam or testimony of faith meaning "There is no God but Allah, and Muhammad is His Messenger" (Al-Huseini, 2006, p. 58). One nurse said: "If dying, say the *Ash-Shahadah* for the patient ...give them a smile, tell the patient if the nurse sees good signs. If there are bad signs, don't tell the family. Nurses must mention God in the last breath, and say the

Islamic *Ash-Shahadah*.” Another nurse spoke about taking care of a Muslim patient in an intensive care unit in Ireland ... She would say *Ash-Shahada* in the ear of the patient when the code team was trying to save the life of the patient.

Patients also seek religious advice and support from the nurses. As explained by a surgical nurse:

Sometimes the patients ask us, how we can pray here? They want to wash for prayer so we advise them after surgery. They ask: "Can we wash for prayer, can we pray now? Can we bend because I want to pray, and God will not forgive me if I do not?" So they start asking because they know that we are Muslim and know how they can wash for prayer.

Many narratives highlighted the use of religious words as a caring action and connecting to the patient relationship. The words *Assalaamu Alaekum* (peace be upon you), *Bisma'allah* (by the name of God), and *Insha'allah* (God's will) were used to make a spiritual connection with the patient and to connect nurse caring actions with the name of God as the basis of the trust between nurse and patient.

Nurses use actions and simple religious words to draw the patient back to their shared belief in God. To assist in relieving pain, one nurse explained, "while you are not really going to relieve their pain, after you give an injection we say *Insha'allah* [God's will] it will be okay, and everything will be okay." The use of these small actions has great impact. A Jordanian nurse explained to me:

You can have connection with the patients in the small actions, when you are doing something critical. Mention the name of the God, *Bisma'allah*, when you come to do something painful to the patient and explain the procedure to him. You will have the patient's trust ... Just say *Bisma'allah*, for small things, it will help. He will tell you, do what you want. He will trust you more. He will believe that you trust God and then he will trust you.

The use of religious words such as *Bisma'allah* is not limited to Muslim nurses caring for Muslim patients, but all nurses prior to any procedure for a Muslim patient. A Muslim nurse explained that non-Muslim nurses should know to say *Bisma'allah* as an action to calm the patient to establish trust between the patient and nurse.

You know, we are even teaching this to our [non-Muslim] nurses because *Bisma'allah* means by the name of the God. In starting a procedure, some of the patients see that a nurse is not Muslim, and they do the procedure and say *Bisma'allah*. They become very happy and even trust the nurse more.

Muslim nurses consider the use of *Bisma'allah* as a form of prayer for their patients, regardless of a shared belief system. "We will say *Bisma'allah* and will pray for our patients, even if they are not Muslim." So, their spiritual caring is not specific only to the Muslim, but "that is how we treat all of our patients."

After I gained this understanding of the use of *Bisma'allah*, I became more observant of actions prior to procedures in my own

personal hospital experiences in Saudi Arabia. A Muslim Filipino lab technician said *Bisma'allah* prior to drawing my blood. On another occasion, a non-Muslim Filipino nurse murmured *Bisma'allah* just before she commenced a cautery procedure on my face.

Reward for nursing actions

A fundamental belief in Islam is that you must live your life in preparation for reward in the afterlife. This is characterised by the saying “you work to live, and work to live the day after.” It follows that the belief in reward for the afterlife underpins the nurse caring role. In addition, nurses link the importance of their caring actions to a verse in the Qur'an (5:32) that gives significance to saving another's life: “if anyone has saved a life, it would be as if he has saved the life of the whole of mankind.” As noted by Moawad (2006 Nursing Code of Ethics in Islam ¶ 1), “The holiness of the Nursing Code of Ethics in Islam is derived from this verse in the Holy Qur'an.” The linking of this verse to both nursing and medical actions was frequently quoted during the research.

The theme of nurse caring leading to reward in the afterlife emerged early in this research when I listened to an opening address by a Dean of Medicine at a nursing conference in Riyadh. My field notes captured the essence of his message about nursing within the context of religious belief in order to seek reward in the hereafter.

His view of nursing was that it was special as nurses live with the patient (meaning 24 hours care), and deal with physical and mental illnesses. He also said that nursing is special, as you “get the

reward thereafter.” This message seemed to be saying to me that nursing is special as God rewards nurses for caring for the sick. He also said, “you work to live, and work to live the day after.” Again, this message was a similar theme of nursing for reward in the afterlife, consistent with Muslim beliefs. (Field notes 9 May 2004)

At the Oman nursing conference (previously discussed), Muneera Al-Osimy (2005) began her keynote address on “Morals and Practices of the Muslim Nurse” with the following excerpt from the Qur’an (16:97):

In the name of Allah, the Most Beneficent, the Most Merciful:
Whoever works righteousness, whether male or female, while he (or she) is a true believer (or Islamic Monotheism) verily, to him We will give good life (in this world with respect, contentment and lawful provision), and We shall pay them certainly a reward in proportionate to the best of what they used to do (i.e. Paradise in the Hereafter).

The use of this verse clearly links nurse caring with righteousness, Islam and reward for the good work. Further, in Al-Osimy’s (2005) remarks she emphasised the importance of reward from God for nursing and advised nurses not to complain or be dissatisfied. She noted that good behaviour and conduct, relieving problems for others, visiting the patient, showing the patient where to face for prayer were all actions making the nurse deserving of entering heaven.

At the Oman conference, Al-Riyami’s (2005) presentation: “Quality Patient Care: A Choice or Professional Obligation,” described nursing as

an “obligation to care” and used a saying from the Prophet (PBUH) to link nursing standards and the caring role with reward in the afterlife. Al-Riyami (2005) conveyed this *hadith* to the audience as the focus of quality and nurse caring:

No one will move from earth until the Day of Judgment, according to how you spent your life, how you used your knowledge, how you earned and spent your money, and your pursuit of health.

You must gladden the hearts of human beings;

Feed the hungry

Help to lighten the sorrows of the sorrowful

Remove suffering from the wound.

Receiving recognition and reward from God and appreciation from the patient were frequent themes in the narratives of the nurses. One nurse explained:

When we are working for the patient, we are putting in something else, that’s our faith in God because we believe in Islam. We know God will appreciate our work whatever the type of nursing, because God is helping us. If I am a patient, I need to receive the same care that I want. If I want to receive a good care, I have to give it first to the patient. That’s why we are giving our care to the patient, because we believe that God looks on us. The patient will say, “See you are doing a very great job” saying to us, “God bless you, God help you.”

According to the nurses, helping a patient to have a longer life brings greater reward over time to the nurses for their good work. The reward and recognition from God accumulates as you care for more patients. A Jordanian nurse explained this concept to me:

I did something good for this patient, for example I saved his life or I did a good dressing. It will increase his life maybe 15 or 20 years. All the good things that he is doing [over his lifetime] mean I will get benefit from it. God will reward me for it. God will not reward me for what I did just once. For example, if the patient is having a cardiac arrest, I help him to get back to life. He comes back to life, he does good things, and then I will get benefit as he is doing good at the same time. God is giving, and God will see how many patients you are dealing with. There are many good things you will receive from God.

Similarly, a nurse's father acknowledged that reward will come for his daughter for her caring. "It will be good for you and good for your patient and as I know that if you do anything good that God will reward you" (Mebrouk, 2004, p. 54). Another nurse talked about the patients appreciating and giving thanks to God for the nurses' caring. This makes nursing special as it comes from their shared religious values.

One of the things that really make me like nursing: if the patient is in pain and says to you: "Thank you, God Bless you." That's a perfect thing for me. Especially in Arab countries there are a lot of people that when you're doing something for them, they are really

praying to God, saying your name all the time. “God bless you, God help you.” This is something, I could receive all the money, but it’s the religion that is important for me. Nursing is not only having a Bachelor of Science education and having a lot of opportunities.

In a group discussion about the research findings, the nurses confirmed the finding that reward comes from the patients praying for the nurse and reward from God as you were doing God’s work. A nurse explained that there are angels all around you and the patient. “There is so much to be received, when the patient says I wish you a good husband, I wish you many children. It is like praying for you. Many years later it will come true because the angels will be there for you.”

“We are the angel in the air”

A nurse saying “*we are the angel in the air*” was an ethnographic moment that came in one of the initial group discussions. A Jordanian nurse described how the nurse practices from a spiritual perspective and how the patient perceives the nurse. “He will feel that you are doing nursing as a profession. But you are not feeling that nursing is just work ... as I said we are the angel in the air. We should be careful with the patient and start our nursing by the name of God.” This symbolism of being angels in the air resonated strongly with the Arab Muslim nurses in discussions as they described various caring actions that related to their own spirituality and that of their patient. This comment captured the

essence of caring as an act of spirituality and central to their meaning of caring.

The symbolism of nursing and angels began when Rufaidah was described as “the first angel who gave mercy and love in Yathreb [Madinah]” (Karahah, 2004, p. 31). This symbolism of the nurses as an angel has some similarity to the Western image of nurses as “angels of mercy,” which began with the European nursing history of nuns caring for patients.

Patients also expressed the symbolism of nurses as angels. A letter of appreciation from a Saudi patient about a non-Muslim nurse linked the values of purity, morality, nobility and generosity and being an angel of mercy. A translation of this letter reads:

I am pleased to thank you and your great hospital services towards one of your employees, when I was admitted before three weeks, the English nurse ‘Varyr’ has fully performed her duty as a nurse with a live conscience, and high purity, she deserves the surname (mercy angels), for her good treatment of patients, good morality, nobility and generosity. So I am not able to be silent unless giving her the rights she deserves as a minimum.

Once the symbolism of the nurse as an “angel in the air” emerged I tested out the idea in various settings, such as conference presentations and discussion groups. The majority of Arab Muslim nurses were enthusiastic that this symbolism captured the essence of their caring. On occasion, a nurse would dispute the concept, but I could not draw out the

reason for this. In contrast, the symbolism evoked a strong response, as demonstrated in the following narrative. While the story concerns a physician, the concept of caring and spirituality is a common thread.

A veiled woman sat at the back of the classroom room where I was discussing my early findings with a group of Muslim and non-Muslim nurses. There was a lively discussion about caring, Islamic ethics, spirituality and “angels in the air.” The veiled woman participated in some of the discussion about the principles of autonomy and Islamic ethics, but was unknown to the other participants. After the discussion she came to thank me and seemed overwhelmed, almost crying. She explained that she was an obstetrics resident physician that had not worked for over 5 years. She had been awake all the previous night, trying to make the decision on whether she would come back to work as a doctor. In hearing my presentation about nurse caring in Islam and the discussion about the angels in the air, she decided that she must come back to medicine to serve the patients. She said it was God's will that she happened to come into the classroom, and she was so thankful to me for talking about Islam and caring. She took my hand and held it for a long time, and then embraced me. After she left, I felt shaken, and a shiver went down my spine. I felt

overwhelmed that the angels in the air symbolism had such a powerful connection for this physician. (Field notes 6 June 2006)¹⁶

Summary

The history of nursing in Islam grounds the nursing identity in the religious values shared between nurses and patients. While acknowledgement of this nursing history is recent in the region, the validation of the nursing role in Islam provides the foundation for caring as an act of spirituality. Rufaidah's narrative symbolises many aspects of caring in Islamic nursing today: the attributes of empathy, kindness, patience and human touch; helping the needy and disadvantaged. The belief that nursing is a means to express and practice the Muslim faith underpins caring as a spiritual action.

Islam is the foundation of the shared values of the nurse and patient, and expressed through caring action. Thus, the nurse's professional and personal identity is inseparable from Islam. Mebrouk (2004, p. 62) states that the nurse's "professional and personal identity appeared intertwined, and inseparable from Islamic values." Faith in God is the basis of the nurse's commitment to their profession and their patients. As with all Muslims, the first duty of the individual is to God, then to their own faith and worship of God. The nurse's relationship with God forms the beginning point of caring for the patient and actions to assist the

¹⁶ I met this physician a year later, and found out that she became a volunteer spiritual advisor at a local primary health care centre, helping to link medical care with spiritual caring.

patient's belief in and relationship with God. Caring actions include reading from the Qur'an, use of religious teaching for patient education and use of prayer or religious words.

The key findings of Mebrouk's (2004) study on "Perceptions of Nursing Care: Views of Saudi Arabian Female Nurses" were validated by the caring actions found in my research. Mebrouk's (2004, p. 75) summary of findings related to Islam and caring actions mirror the findings of my study as follows:

Islam is paramount to participants, and was in various ways involved in their nursing care, not on a convenience basis, but through thoughts and actions that became evident in the exploration of their experiences in nursing care. The participants described various combinations of conventional and cultural traditional medicine. Reading the Qur'an, praying, and encouraging the patients to listen to religious teaching were mentioned as nursing interventions. Health teaching was described as being more effective and appropriate if related to foundations in Islam, the Qur'an or Sunna. Demonstrating respect for religious acts, such as praying for end-of-life rituals, was deemed essential to care. Understanding the value of Zamzam and honey in care perspective enabled the participants to combine this knowledge with the more scientific perspective.

Islam's saturation within the participants' nursing care experiences was at many levels subconsciously expressed. This was

interpreted to be caused by the taken-for-granted concept. The participants and the patients had shared values and this brings on familiarity, rendering interventions to tacit understanding and taken-for-granted interventions.

The verse in the Qu'ran (5:23): "if anyone has saved a life, it would be as if he has saved the life of the whole of mankind" is significant to the belief that nursing is a spiritual action that will bring rewards in the afterlife. Receiving recognition and reward from God are central goals for all Muslims, and caring is a means of achieving this outcome. The imagery of nurses being the angels in the air captures the meaning of caring for Arab Muslim nurses, caring for and being guardians of a patient's spiritual and physical health.

Exploration of the ethical foundation to the nurses' caring emerged from understanding that caring is a spiritual action. As Islam provides the foundation for nurses' caring, it makes sense that Islamic values will guide ethical decision making. A more comprehensive understanding of caring emerges through exploration of these ethical aspects of caring as presented in the next chapter.

Chapter 6: Ethical Dimensions of Caring

Introduction

This chapter presents my journey to understanding the ethical foundation for Arab Muslim nurses' caring. The ethical dimensions of caring emerged as an area for attention and explanation as I listened to Muslim and non-Muslim nurses discuss the ethical dilemmas they faced when caring for Muslim patients at King Faisal Specialist Hospital & Research Centre in Jeddah. Consistent with the finding that Islam is central to nurses' caring, I discovered that Islamic bio-ethics is the basis of their ethical approaches in the caring experience. While recognition of the ethical dimensions of caring was not an intended outcome of this study, this knowledge adds another aspect to understanding care meanings within this cultural context.

I present a comparison of Western and Islamic bio-ethical perspectives based on available literature and consultation with an Islamic bio-ethics expert. The development of an ethical decision making approach for nurses in an Islamic predominant health care environment will be described and applied in a case study on organ donation.

Recognising differences in ethical perspective

My first insight into the distinct ethical framework that guides Arab Muslim nurses occurred prior to this study, when I participated in a multicultural task force to develop a code of ethics for a proposed nursing council for Saudi Arabia in 2000. The draft Code of Ethics referred to

Shar'ia law, the Islamic ethical system, and axioms of Islamic ethical philosophy as the basis for ethical conduct in nursing (Saudi Board of Nursing Profession, 2000). Subsequent discussions within this task force on nursing ethics within the context of Islam raised my desire to understand the similarities and differences to Western biomedical ethical principles.

During this study, I recognised that Muslim and non-Muslim nurses approached ethical dilemmas, such as discontinuing life support in a critically ill patient, assisting with organ donation or procedures such as abortion and sterilisation from different ethical perspectives. For example, discontinuing medical treatment for patients who are clinically dead creates an ethical dilemma for Muslim and non-Muslim nurses. In the Muslim view, Allah decides the time of death, so health providers must not withdraw life saving measures (Rassool, 2004). In contrast, non-Muslims may perceive continuation of life support as causing unnecessary suffering (Gebara & Tashjian, 2006; Halligan, 2006). In the intensive care setting, I often heard non-Muslim nurses express ethical concerns on the way the Muslim physicians continued life support “unnecessarily”; these nurses could not understand “why the patient was not permitted to die.” In contrast, the Muslim nurses would respond, “we cannot discontinue treatment as life and death are up to Allah.”

Discussions on sterilisation and abortion procedures highlight different perspectives on the value of patient autonomy. The Western bio-ethical perspective gives priority to the values of autonomy and patient rights, thereby supporting sterilisation and abortion procedures (and the

abortion debate centres on rights of the mother versus the rights of unborn baby). As explained by Arab Muslim nurses during a discussion on Islam and caring, sterilisation is not supported in an Islamic bio-ethical view as it is interpreted as interfering with reproduction and God's will. Islamic bio-ethics prohibits abortion as human life is given by God and cannot be taken away except by God. The only exception is when the mother's life is at risk, as the mother's life takes precedence over the unborn child (Moawad, 2006).

Discourse in nursing assumes a shared understanding of what constitutes ethical decision making. Nursing texts and articles commonly draw from the ethical theories of utilitarianism¹⁷ and deontology¹⁸ and define ethics according to the principles of beneficence, non-maleficence, respect for autonomy, fidelity, justice and veracity (Taft, 2000). These principles and theories derive from the religious and philosophical traditions of Western culture and form the basis of international ethical guidelines such as the Declaration of Helsinki (Harper, 2006; Pacquiao, 2003; Taft, 2000). There is recent recognition that Western ethical principles may or may not reflect the values of developing countries or non-Western cultures (Christakis, 1992; Crigger, Holcomb & Weiss, 2001; Harper, 2006; Tschudin, 2005). In the case of ethical principles applied in an international context, the debate is whether there is a universal set of principles applicable to all cultures; whether culture defines ethical

¹⁷ Utilitarianism refers to ethical actions that are judged according to the rightness or wrongness of the consequences of those actions

¹⁸ Deontological ethics focuses on the rightness or wrongness of actions themselves

principles; or whether a basic set of principles exist that can be modified to fit the cultural context (Harper, 2006).

Christakis (1992) argues that culture shapes both the content and forms of moral and ethical systems, and ethical behaviour needs to fit within the framework of the local context. Referring to medical research ethics, Christakis (1992, p. 1080) notes, "Ethical rules are generally based upon profound religious and philosophical beliefs held by a given people, and, thus, the ethics regarding research with human subjects might, *a priori*, be expected to vary cross-culturally." Pang et al. (2003) found cross-cultural variation in perceptions of ethical responsibilities in a survey of Chinese, Japanese and American nurses. In that study, Chinese nurses were virtue-based, Japanese nurses were care-based and American nurses were principle-based in ethical decision-making.

From the insights gained in listening to Arab Muslim and non-Muslim nurses, I suggest that there is not a universal set of ethical principles in nursing, as moral belief systems that underpin nurses' ethical behaviour are culturally constructed (see also Pang et al, 2003). There are similarities as well as differences in the ethical principles applied within the nursing context across cultures.

Islamic bio-ethics

To begin to understand the ethical framework used by Muslim nurses, I looked at the published literature on Islamic bio-ethics. There is some literature published in medical journals to guide the care of Muslim patients (e.g., Al-Qattan,1992; Daar, 1989, 1991; Daar & Khitamy, 2001;

Gatrad & Sheikh, 2001; Hedayat & Pirzadeh, 2001; Rispler-Chaim, 1989; Sachedina, 2005; Sahin, 1990). In general, the focus in these articles is on the ethical issues of organ transplantation, genetic manipulation, termination of pregnancy and end-of-life care. I located two codes of medical ethics based on Islamic principles: the Islamic Code of Medical Ethics adopted by the International Organisation of Islamic Medicine (1981) and Ethics of the Medical Profession published by the Saudi Council for Health Specialties (2003). With the exception of Rassool (2000, 2004) and Moawad (2006), there is limited literature that addresses Islamic bio-ethics within the nursing context. Codes of ethics for Muslim nurses, such as the Gulf Co-operation Council (GCC) Code of Professional Conduct for Nursing (GCC Health Ministers Council Executive Board, 2001) focus on the core values of accountability, dignity, privacy and confidentiality, but do not articulate the principles of Islam inherent in the code of ethics. According to Rassool (2000), the principles of Islamic ethics applied in nursing are the preservation of faith, the sanctity of life, alleviation of suffering, promoting what is good (beneficence), and forbidding what is wrong (non-maleficence).

In my study, Dr. Abdulaziz Al-Swailem, an Islamic bio-ethics expert, provided advice on the application of Islamic principles within the hospital context. Dr. Al-Swailem is Chair of the National Committee of Bio-Medical Ethics in Saudi Arabia, Vice-Chairperson of the World Health Organisation International Intergovernmental Bioethics Committee and member of the International Islamic Bio-ethics Committee. I first met Dr. Al-Swailem following a presentation on "Bio-ethics from the Islamic Point

of View” (Al-Swailem, 2006) where we discussed the ethical dilemmas faced by nurses in the hospital and the lack of resource material on Islamic bio-ethics in nursing. A year later, we collaborated to present an expert session and panel discussion on Islamic bio-ethics in nursing titled: “Ethical Perspectives at the Bedside” (Al-Swailem & Lovering, 2007), at a major nursing conference in Jeddah, Saudi Arabia.

According to Al-Swailem (2006, 2007), Islamic bio-ethics derive from a combination of principles, duties and rights and the call to virtue. The values of Islam, teachings of the Qur’an and interpretation of Islamic law guide ethical decision making. Thus, bio-ethical deliberation is inseparable from the religion, which emphasises continuity between body and mind, the material and spiritual realms, ethics and Islamic jurisprudence (Al-Swailem, 2006; Daar & Khitamy, 2001). Hanson (2008) explains that the Islamic legal system can be reduced to two principles: accrual of benefit and the warding off of harm. Avoidance of harm takes priority over the accrual of benefit as the primary principle when determining ethical action. Al-Swailem (2006, 2007) explains that there are five working principles from Islam to apply to bio-ethical decision making: preservation of life, protection of the species, preservation of mental facilities, preservation of wealth, and the need to maximise the good and minimise harm or evil. In addition, the principle of justice requires that there is fair distribution of benefits and burdens, so that persons receive that which they deserve and to which they are entitled.

Western and Islamic bio-ethical perspectives: A comparison

As background for the expert panel discussion on “Ethical Perspectives at the Bedside” (Al-Swailem & Lovering, 2007), I compared the Western and Islamic ethical principles that guide nurses’ ethical decision making in a session titled: “Nursing Ethics through a Cultural Lens” (Lovering, 2007a). In the absence of literature on Islamic bio-ethics in nursing to guide such comparison, I drew from Rassool (2000, 2004), Al-Swailem (2006) and Daar and Khitamy (2001) to develop this session. The following is a summary of the key points presented (Lovering, 2007a).

In Western philosophy, the four key principles that guide ethical decision making are autonomy, beneficence, non-maleficence and justice (Elliott, 2001). As noted by Daar and Khitamy (2001), secular Western bio-ethics is rights based, with a strong emphasis on individual rights with autonomy as a dominant value. In contrast, Islamic bio-ethics emphasises the duties and obligations of the Muslim to adhere to Islamic principles. The most important obligations are to preserve the faith and to protect the sanctity of life (Al-Swailem, 2006, 2007; Daar & Khitamy, 2001). Western and Islamic bio-ethics share the similar principles of justice, beneficence and non-maleficence.

Western bio-ethical approaches commonly use theories of deontology and utilitarianism in ethical decision making (Brody, 1988). Islamic bio-ethics speaks about the call to virtue, referring to *Ihsan* (striving to perfection). For the Muslim, *Ihsan* is a continuous attempt to

do all things well, drawing nearer to perfection knowing that Allah is watching. Therefore, the call to virtue emphasises the character of the person in the ethical decision. This is similar to the concept of virtue ethics in Western bio-ethics, which focuses on the character of the moral agent (person) rather than the rightness of an action in analysing ethical conduct (Brody, 1988; Gardiner, 2003). In both Islamic and Western bio-ethics, the focus is on both the actions and outcomes of ethical decision making.

Developing an ethical decision making approach

As part of the expert panel (Al-Swailem & Lovering, 2007), we invited Muslim nurses to present case studies for discussion. To guide the panel discussion, I looked for an ethical decision making model that could accommodate decision making using Islamic principles, but was unsuccessful. The majority of models in the nursing literature use a rights based approach, supporting the principle of preserving an individual's autonomy and client choice (Hook & White, 2003; Mylott, 2005; Pacquiao, 2003). I looked closely at Pacquiao's (2003) culturally competent model of ethical decision-making. Pacquiao's model uses Leininger's (1991) theory of culture care and recognises that ethical caring must be culturally congruent. This model aims to preserve human rights and incorporates the ethical principles of beneficence, non-maleficence and justice as part of the values of the client. Thus, it supports the values that are common to Western and Islamic bio-ethics. However, Pacquiao's model assumes that the care giver is of a different culture to the recipient, so is generic in approach and did not appear to guide the application of Islamic principles

(preservation of the faith, preservation of life). I later found Ray (1994) proposed a framework for transcultural nursing ethics that incorporates the ethics of virtue, principle, cultural values and religious beliefs. Ray's model warrants closer examination for congruence with Islamic bio-ethics for nursing and has similarity to the approach developed by our expert ethics panel (Al-Swailem & Lovering, 2007).

In the absence of suitable model (at the time), I worked with Dr. Estelle Bester, Nursing Education Program Coordinator at the King Faisal Specialist Hospital & Research Centre, Jeddah, to create an "ethical decision making approach for nurses in an Islamic predominant health care environment" (Figure 3). With Dr. Bester, the "ethical decision making approach" diagram evolved through our discussions on the interaction of Islamic values, culture and ethical decisions. We tested the evolving diagram with expert insiders to see if it made sense to them. Lastly, I validated the diagram with Dr. Al-Swailem as the Islamic bio-ethics expert. The diagram worked with real case studies in the interactive session with Muslim and non-Muslim nurses (Al-Swailem & Lovering, 2007). On reflection, my insight into the centrality of Islam in the shared worldview of the nurse and patient-family unit, and the influence of culture on the caring experience as gained through my research guided the development of the "ethical decision making approach" diagram.

The core elements of the "ethical decision making approach for nurses in an Islamic predominant health care environment" (Figure 3) are Islam, culture and the patient-family unit. Islamic values are the starting point for ethical decisions and form the foundation of decision making.

Islamic values (represented by the blue area) impact on the patient and family, culture, the nurse, the physician, and the organisation. The patient and family are in the centre cradled by the crescent, which symbolises spirituality in Islam. Culture and customs influence the patient and family within the ethical situation, and may be in conflict with the religious requirements. Professional values and personal belief systems are placed outside the core as the religious and cultural perspectives are more central to the worldview of Arab Muslim nurses.

In order of importance, the following questions were asked to clarify the aspects of an ethical situation: 1) What are the values in Islam that guide this situation? 2) What are the cultural values impacting on the situation? 3) What are the perspectives of the nurse, the physician and organisational policies? 4) What are the professional values that guide this situation (such as a code of ethics)? 5) What are the nurse's personal beliefs? This ethical decision making approach guided the following case study as presented to the expert ethics panel by nurses working in a paediatric intensive care unit (Al-Swailem & Lovering, 2007).

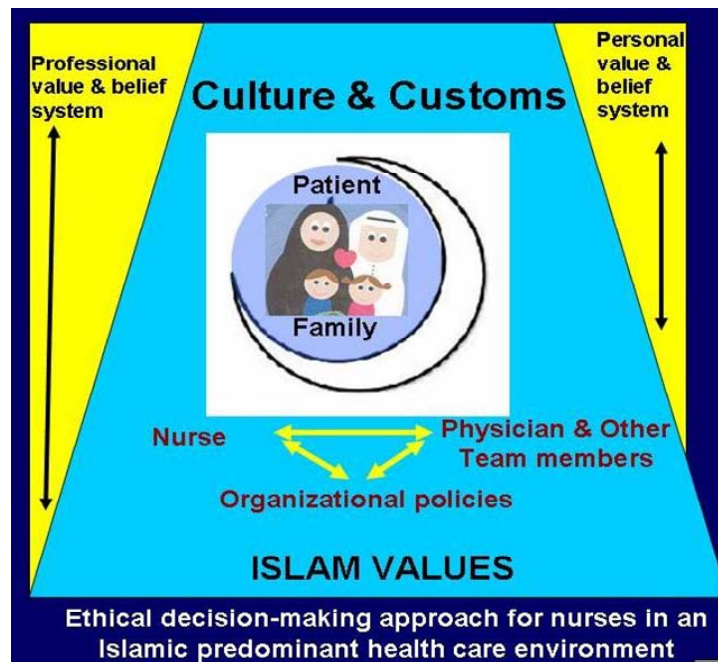


Figure 3. Ethical decision-making approach for nurses in an Islamic predominant health care environment

Case study of an ethical dilemma

Scenario: A six year old female child had experienced severe smoke inhalation and burns following a house fire and was admitted to the paediatric intensive care unit in critical condition. A few days later tests confirmed that she was brain dead and a request for organ donation was made to the family. The following day, the organ transplant team arrived and the child was taken to the operating theatre for removal of several organs.

The nurses raised this case as it was the first time they had dealt with the ethics of organ transplantation. There is a belief among many Muslims that Islamic law prohibits organ transplantation and some

disagreement exists between Islamic scholars and jurists (Daar, 1989; Sahin, 1990). However, organ transplantation is performed in the majority of Muslim countries under conditions specified by a *fatwa* (religious ruling) (Daar, 1989).

The Jordanian nurse caring for this child and family explained that he did not know if organ transplantation was acceptable in Islam. Consistent with the ethical principle that the Muslim nurse must maintain his or her faith, this nurse first went to the religious advisors at the hospital to find out if organ transplantation is permissible. He found out that there was a religious ruling (*fatwa*) giving permission for organ transplantation. From his view, he could then discuss transplantation with the family as it was acceptable in the religion and, in turn, he could support the family in their religious beliefs. After he had met his religious obligation to himself and the family, he considered the cultural needs of the family (involving the whole family in the decision, giving time for family discussion and to consult with the religious experts). After meeting the cultural needs, the organisation and professional aspects were considered in planning for the eventual organ removal.

Another Arab Muslim nurse expressed his ethical discomfort with the decision for the child to be an organ donor, as Muslims believe that the body must be whole when meeting Allah on the Day of Judgement. He believed that removing organs from the body meant violation of the sanctity of the body. When assured that there was a *fatwa* permitting transplantation, he continued to feel uncomfortable that he did not meet his obligation as a Muslim nurse to protect the child's body from

mutilation. This nurse found it difficult to resolve the application of conflicting ethical principles and obligations within his faith in caring for the child and family. The Islamic bio-ethics expert on the panel commented that this view was the personal view of the nurse, the Islamic principles (as expressed through the *fatwa*) take precedence, and that organ transplantation did not constitute mutilation of the body as it was giving life to another.

A non-Muslim nurse who professed a strong Christian belief system also cared for the child and family during the decision to support organ donation. She explained to the expert panel that there were no ethical dilemmas for her, as organ donation was consistent within her belief system. She directed her caring at meeting the cultural and psychological needs of the family, as well as the physical caring of the child. There was a spiritual aspect to her caring from her Christian belief system (to provide care as God would want her to be caring), but this was not spirituality based on a shared value system with the patient and family. Placing the organ donation decision within the Islamic belief system for the family was not part of her caring action.

In analysing this case study, many of the elements of Islamic bio-ethics are present. The two primary principles of maintaining the faith (ensuring that transplantation was permissible), sanctity of life and the accrual of benefit (transplantation was to save the lives of others) guided the Arab Muslim nurses' actions. The principle of beneficence (promote the good) and the call to virtue (doing right in the sight of Allah) apply as well. In contrast, a non-Muslim nurse did not experience ethical conflict in

her caring as the Islamic spiritual aspect (is organ donation permissible?) was not a factor. While she cared from her own sense of spirituality, the shared meanings with the patient and family did not inform her caring action or ethical decision making.

Through reflection on this case study, the integration of Islamic ethical beliefs into Arab Muslim nurses' caring experience is apparent. Nurses must maintain their faith in all caring actions, and use this faith to guide their ethical action. The principles that guide ethical behaviour in Islam guide nurses' moral decisions in their caring. As such, Islamic bio-ethics informs the meaning of caring for Arab Muslim nurses and is an important dimension of caring action.

Summary

Culture determines the personal and professional values and beliefs that guide all nurses' ethical reasoning. The majority of the literature on nursing ethics reflects the Western belief system that many assume to be the defining standard of health care ethics (Taft, 2000). The principles of beneficence (do good), non-maleficence (avoid harm) and justice (fairness and equity) are shared by the Islamic and Western bio-ethical systems. Western nursing ethics are rights based with an emphasis on the value of autonomy (Elliott, 2001). In contrast, Islamic nursing ethics emphasise duty and obligation to the principles of preserving the faith and the sanctity of life (Al-Swailem, 2006; Daar & Kitamy, 2001; Rassool, 2000). Both ethical approaches consider the actions and outcomes of ethical decision making.

As caring is an act of spirituality, Islamic values and jurisprudence must guide ethical action. The ethical dimension of caring encompasses the achievement of spiritual health and maintaining the faith within the caring experience. The explanatory models of the nurses as derived from Islamic values, caring as a spiritual action and ethical dimensions of caring have presented a picture of caring derived from the religion. I now turn to a specific form of caring from the cultural perspective: the protection of dignity as a caring action.

Chapter 7: Cultural Caring — Protection of Dignity

Introduction

The numerous narratives conveyed around issues of gender in the nurses' caring experiences highlighted the importance of protecting the dignity of the patient and the nurse. Protection of dignity as a caring action encompasses the need to preserve modesty and privacy and meet cultural expectations of gender-specific caring and gender segregation in the health care encounter. *Hejab*, meaning separation, is the Islamic value that underpins expectations for gender-specific caring and gender separation as interpreted through a cultural lens. In present times, hejab primarily refers to the Islamic dress where a woman should cover part or whole of the face and most of her body (through veiling and conservative dress) for the preservation of modesty.

This chapter discusses the religious and cultural values, as well as regulatory directives around protecting the dignity of patients, and describes the impact of gender on the caring relationship. Expectations for gender-based caring and gender segregation in the health care encounter highlight the importance of preserving the dignity of patient and nurse within the cultural context.

Chastity and modesty: The religious view

The need to protect the dignity of both the patient and the nurse arises from the religious requirement to preserve chastity and purity. Chastity is a fundamental value for both genders, but of greater

significance for females. In a strict sense, Muslims must not engage in sexual relations outside of marriage and the Qur'an sets out a variety of guidelines that regulate behaviour and interaction between males and females, including the requirement for gender separation. Males and females must refrain from looking at forbidden things and protect their private parts from illegal sexual acts. Females are required "not to show off their adornment" and "to draw their veils all over *Juyubininna* (i.e. their bodies, faces, necks and bosoms)", only removing their veils to male relatives, other Muslim women and children (Qur'an 24:30-31).

The value of chastity and purity within Islam comes from the story of the virgin Maryam (Mary) giving birth to Isa (Jesus). Chastity is linked with the virginal conception in the Qur'an (21:91), "And she who guarded her chastity [Virgin Maryam (Mary)]: We breathed into (the sleeves of) her (shirt or garment) [through Our *Ruh* – Jibril (Gabriel)¹⁹, and We made her and her son [Isa (Jesus)] a sign for Al-Alamin (the mankind and jinn)". While Islam and Christianity share the same history of the immaculate conception of Isa (Jesus) the values of chastity and purity are interpreted and actioned differently, such as the requirement for gender separation in daily life in Islam. Within Christianity, the story of the virgin birth of Jesus is central to the faith but interpreted differently according to various denominations.

The need to maintain chastity is located within the important Arab cultural value of family honour, thus is a shared value for Arab Christians

¹⁹ Referring to the angel Gabriel

and Muslims. Regardless of gender, an Arab is not an individual who may act freely as all actions reflect on the honour of the family, tribe or community. The family, rather than the individual, is the core of the religious–political–community (Erktuk, 1991). The woman has responsibility to maintain the honour of the (family) group by maintaining her own purity and chastity through respectful behaviour. Arab Muslims maintain honour through the social institutions of veiling, seclusion of women and strict segregation of the sexes. Arab Christians also value respectful behaviour as a reflection of the woman's honour. The protection of the woman's honour, hence family honour, is the responsibility of the male members of the family. Therefore, the preservation of the family rests in the moral conduct of women as protected by men. Thus, there is a blending of religious and cultural beliefs around modesty and protection of dignity of particular significance for females in the Middle East.

Protection of dignity and privacy as mandated by regulations

Actions to maintain dignity and privacy as required by Islamic values are embedded in the codes of conduct for nursing in Arab Muslim countries. While these professional codes distinguish between dignity and privacy, in practice maintaining dignity encompasses the concept of privacy. The Gulf Co-operation Council (GCC) Code of Professional Conduct for Nursing (GCC Health Ministers Council Executive Board, 2001) applies to nurses practising in the United Arab Emirates, Bahrain,

Saudi Arabia, Sultanate of Oman, Qatar and Kuwait. The concept of dignity is a fundamental value that encompasses actions to protect the self respect of vulnerable patients and maintain privacy by limiting access to a person unless necessary for care provision. The Code of Professional Conduct for Nurses and Midwives in Oman (Oman Nurses and Midwifery Council, 2005) is more explicit about preventing unnecessary exposure of the body. “Privacy must be protected during all care administered to the patient or client, and measures taken to ensure that unnecessary bodily exposure does not occur” (Oman Nurses and Midwifery Council, 2005).

Regulatory directives that govern hospital operations mandate actions to protect patients’ modesty and privacy, such as the document titled: “Administrative and Procedural Rules for Observing Decency of Patients’ Auras,” issued by the Minister of Health in Saudi Arabia in September 2005. According to this document, *aura* is a transliteration of an Arabic word, which means the parts of the body that should be covered. For a man, *aura* includes parts of the body from the navel to the knee. For a woman, *aura* includes all the parts of her body except the hands and face. This document provides general rules for caring, special rules for the outpatient and emergency departments and admission wards, directions for transferring patients between departments in the hospital, and protection of patients’ privacy in the operating room.

Segregation of male and female areas in waiting rooms and clinics is required. Protection of the female patient in any potential interaction with a male is emphasised. Males may not enter a female patient room unless accompanied by a female nurse or the patient’s companion, even

if the male is part of the treating team. A female nurse must remain with a female patient during surgery and is responsible for “appropriately concealing the *aura* of the female patient, covering her entirely, including the covering of her head and face and maintaining her privacy throughout all stages of her movement” in the operating room. There are strict requirements that catheterisation must be done by same gender caregivers (Minister of Health, Saudi Arabia, September 2005).

This protection of female modesty is integral to Arab Muslim nurses' caring. In her research on caring by Saudi nurses, Mebrouk (2004) found that protection of dignity and modesty by covering *auras* was a taken-for-granted action. Mebrouk (2004, p. 61) noted that “the participants would ensure that Saudi Arabian female patients remained appropriately covered at all times, even when unconscious.”

Arab Muslim nurses point out that non-Muslim nurses do not have the same understanding of the need to protect the privacy of patients. One nurse observed, “Privacy is very important for a Muslim, especially for female and male issues ... for the Western person, privacy is not as big a deal as it is for the Muslim person.”

Patient expectations for gender specific caring

There is no religious or cultural requirement for gender separation in all caring encounters. The narratives of the nurses shed light on various interpretations of the need for gender specific caring. An Egyptian nurse noted that “as a Muslim, we have to satisfy our need for caring by the same sex. If I'm a female patient, I have to pick a female nurse, if I didn't

find a female nurse, it's a male nurse. But first of all, it should be a female nurse. This is from our religious part, which we adapted from the international view of nursing.”

Patient expectations for gender-based caring are dependent on the degree of conservatism within the culture. A Jordanian nurse working in Saudi Arabia explained how the Saudi patients are more conservative than he experienced as a male nurse in Jordan and how a (Filipino) non-Muslim male nurse would need to adapt his care with a female Muslim patient in Saudi Arabia.

For a Filipino nurse, and especially if he is a male, we have to tell him that he can't enter the male patient's room if the patient has a female visitor (like his wife or his daughter), unless the nurse takes permission first from the patient. He can't take care of a female patient unless he takes permission from her and he can't even enter the room by himself. In Jordan, we still take care from the gender view, but it is fine with some patients that a male [nurse] takes care of a female patient. Here [in Saudi Arabia] you'll find different people. You'll rarely find a female patient that will accept a male nurse to take care of her.

Another male nurse explained that he was able to work on a female unit without problems in Jordan and believed that the cultural views about gender-specific caring were beginning to change in Saudi Arabia. “Here in Saudi Arabia, all of the people believe that the male nurse can't work with the female patient ... They look for the care ... if you

put care, the female will accept him and these ideas start changing in the people here.” Another nurse explained there was less conservatism around gender segregation in Muslim societies where there are other religions such as Christianity, as in the case of Jordan.

In some cases, the health care team may be unable to accommodate the patient’s expectations for gender specific caring and this may result in unsatisfactory outcomes. This was the situation faced by a Saudi nurse working as a bone marrow transplant coordinator. She understood the religious value placed on modesty, but could not reconcile the father’s view to protect the wife’s dignity at the expense of the life of the child. This is an example of a critical incident, where the nurse tried to find meaning in the experience.

A young child required a bone marrow transplant and the mother was to be the donor. As a donor, the mother would go to the operating room for the harvesting of the bone marrow under a general anaesthetic. The husband (father of the child) was very concerned that the surgeon and anaesthesiologist performing the procedure were male and insisted that the entire team be female; however, no qualified females were available. The bone marrow transplant team assured the husband that the privacy and dignity of the wife would be protected at all times, to avoid any exposure of the patient’s aura. The husband then insisted that he be present in the operating room to protect the modesty of his wife. The team could not allow his presence due to the nature of the operation and the strict infection control procedures required. The husband

continued to refuse to permit the operation to proceed and the child subsequently died from the cancer. The nurse was distressed that the husband held such strong values for maintaining the wife's modesty, leading ultimately to the child's death. As a conservative Muslim, she understood the importance of maintaining modesty, but found it difficult to reconcile that the husband placed the value of modesty above the necessity of the operation to save the child's life. According to the nurse, necessity overrides the forbidden in Islam. (Field notes, 23 April 2007)

In another scenario that I experienced as a nursing administrator, a male patient requested gender-specific caring for an elective ophthalmic surgical procedure. The patient came to his pre-admission clinic visit and insisted that all of his care team must be male. Due to his strict religious beliefs on maintaining modesty and purity, he could not let a female touch or talk to him. In his view, strict gender segregation was required for protection of his purity. We accommodated his request by rescheduling his appointments and operative procedure when we were able to arrange the staff schedule for male carers in the day surgical unit, operating room and clinic. In this scenario, there were no barriers to arranging gender-specific caring and the outcome was positive for the patient.

The need to accommodate gender-specific caring is a reality within the hospital setting in more conservative societies such as Saudi Arabia and Oman. As a nursing administrator in Saudi Arabia I continuously balance the male and female mix of nurses in organising nursing services to meet patient expectations and organisational requirements.

Nurses' views on gender-specific caring

Arab Muslim nurses do not subscribe to the view that caring must be gender-specific at all times. In particular, female Muslim nurses can care for male patients in the majority of situations. Nurses practice from the view that their religion supports their caring and transcends the cultural values.

My research on Saudi nurse leaders (Lovering, 1996) identified the obligation to care regardless of gender. These nurse leaders differentiated between Islamic teachings and cultural preferences, noting that the early Islamic (female) nurses cared for male soldiers, and Rufaidah looked after male patients in the mosque. A nurse observed that “in Islam, it does not say that the women cannot work with the ill (male) patients” (Lovering, 1996, p. 51). Mebrouk (2004) also found that the female nurses did not have major concerns if their patient assignment would involve care for a male patient in her study of caring by Saudi nurses.

Impact of gender on the caring interaction

Cultural values around gender impact on the caring interaction. According to the nurses, care is adapted to protect the modesty of both patient and nurse, and this varies among the individuals interacting. The nurses felt that care by a nurse of the same gender is more complete because the need to limit the use of touch and eye contact with the opposite gender hinders the care process. One nurse commented that gender created barriers for both sides. “From the patient’s point of view and from a nurse’s professional point of view: when I care for the opposite

sex, there is a social and religious background that hinders both of us in expanding our concept of care.” Another female nurse noted, “When we care, female to female, male to male, we can expand all our concepts of care” and “touch in care is very important from the patient’s point of view. As a female, touching is important, but when I’m caring for a male, my touching will either be hindered or ineffective.”

The use of touch is a fundamental action by nurses within the caring relationship. Islamic teachings restrict or prohibit touching between unrelated males and females in order to prevent immoral behaviour. This does not preclude physical contact where there is justification and need. As noted by Al-Shahri (2002, p. 136),

Islamic teachings forbid unnecessary touching (including shaking hands) between unrelated adults of opposite sexes. Observance of such teachings is probably expressed more commonly by female patients when cared for by male health professionals ... some Saudis may appear to accept being touched by health professionals of the opposite sex. This does not necessarily mean absolute voluntary acceptance. Indeed, they might feel very bad about it and only consented to it to avoid embarrassing the “authority figures,” that is, health professionals.

All female nurses acknowledged the value of avoiding touch of unrelated men, but recognised that some form of touch was necessary when caring for a male patient and described it as “professional touch.” “Eye contact and physical touch with a person of the opposite sex was

recognised as inappropriate, however male patients were to a certain extent exempt, and the participants would go about this in a professional way” (Mebrouk, 2004, p. 75). Another nurse compensated by seeing the patient as a member of her family. “It’s like if you deal with someone from your family, like your father or your uncle. If I deal with someone in my age group, it is like a brother.”

I did not explore the importance of touching from the patient’s view with the nurses. An interesting observation was noted in a study of Muslim patient’s perceptions of a caring nurse in Malaysia (Nahas, 1997) where comforting a patient by touch was not considered an important nurse caring behaviour by the patients. Nahas attributed this finding to the cultural taboos related to religious beliefs and segregation practices.

Care involving the genital region

There are further restrictions on care involving the genital region for both genders out of respect for the patient and nurse. Males may not provide genital related care for female patients. Mebrouk (2004) notes that female nurses are less restricted when caring for male patients; however, physical assessment of the genital area was impossible. On the other hand, a non-Muslim female nurse may provide this care as she does not face the same religious and cultural sanctions. The male patient is aware that the non-Muslim nurse is not constrained by the same requirements for modesty so, in turn, there is less compromise of the patient’s dignity. As one nurse explained, “a male patient would accept a Western female nurse by the majority [of Saudi male patients]. But it’s

very rare they would accept a Saudi female nurse. Why? Because he feels that you know, that I know, that you know, you see?”

Another nurse explained how assigning a non-Muslim nurse could protect the modesty of the female Muslim nurse.

When I worked in a hospital in Egypt, my supervisor was Egyptian and an Arab Muslim. She knows our culture so she did not assign a Muslim nurse in the surgery clinic or urology clinic because it was too difficult for us to see the genital organs of the males. In our religion and culture, it's really not good. So she put a Filipino nurse in these clinics as it doesn't matter for them.

Some restrictions may apply for female to female caring by Arab Muslims. “Even for the female, it's not good to see another [female] from the umbilical to the knee unless there is really a good reason for that ... you will look only if there is a reason, but not for show. We cannot expose ourselves to each other.”

The need to care for patients who are unable to care for themselves overrides this prohibition to view the genital area by either gender, such as in the intensive care (ICU) or emergency setting. “If you are working in the ICU there is no problem, you can do a dressing for the genital area.” Another nurse explained,

In the ICU the patient is unconscious and you have to do it. I worked in Egypt for 10 years before I came to Saudi Arabia. In ICU we gave the complete bath to the patients, male or female. In the area from the buttocks to the sides we will give complete care. If

the patient is disorientated, unconscious and with no companion, you are the one who will give all the care for the patient.

Procedures such as catheterisation create special circumstances. Protection of dignity includes protection of virginity and reputation (chastity) of the female. A Muslim nurse working in the Emergency Room used this example to explain how non-Muslim (Western) nurses do not appreciate the cultural importance of protecting virginity during catheterisation:

I'm sorry to say, but if they're Western nurses they will go ahead and insert the poly catheter into the female patient without asking. When the patient is not married, as a Muslim we will take care of her virginity. The Western nurse does not think about it. This happened to my friend (a nurse) and I had explained the difference to her. We are Muslim and we care about the virginity, especially if she is female, and she is not married. You have to ask the patient before you insert the poly catheter if she is married or not.

Female nurses felt strongly that they could not do a male catheterisation, as it was so against their cultural values. In one story, the nurse was willing to lose her job if she had to catheterise the male patient. Fortunately, a Filipino nurse understood the dilemma of her colleague and offered to do the procedure.

I was in x-ray department and doing an IVP. They were inserting urinary catheters for males and females. Female catheter, it's ok for me, I can insert it no problem. But for the male ... it happened

one time. It was my turn to insert the catheter and I refused, strongly refused. I said to the x-ray technician, if they terminate me I would not insert it. The Filipino nurse who was working with me said, “I know your culture. I am the one who will do it.” So she rescued me from this situation.

Protection of the Arab Muslim female nurses’ dignity

Patients and nurses bring their cultural beliefs about dignity and modesty to the nurse–patient interaction. Some male patients interpret the nursing role and some caring actions as breaching the cultural barriers and view the nurse as a female of immodest or immoral character. In turn, the patient will act inappropriately from the cultural view of what is acceptable between a male and female. An Egyptian nurse explains,

In Egypt, the patient is used to having care from female nurses. Because of our culture, the female should be treated only by a female and the male should be treated by male. In the hospital, [with the patients] there is a misunderstanding. The male patients start to get confused between “this is a woman” and not “the nurse.” Other ideas come to him. This is a woman and they speak the language, she is free, she is not covered, she is open so there is no problem if we talk to her [inappropriately].

The female nurse responds to the inappropriate behaviour from her cultural values and experiences a loss of dignity. The nurses respond by taking a professional caring perspective or involving male or non-Muslim

(Filipino) nurses in caring for the transgressing male patients. One nurse explained:

It's difficult as a female Arabic Muslim to deal with a male patient. For example, we have a rectal sinus dressing and the [male] patient would not behave. So I called the male nurse to "please come and do this one." Some of them behave and I tell them to just lie down on your face, turn your face, then I cover them. But if I see him try to do something [inappropriate], I will call a male nurse. This is a big point for us.

Another narrative shows how nurses changed practice to protect the dignity of patient and nurse. Female Arab Muslim nurses working in a pre-admission assessment clinic had difficulty taking the patient history concerning prostate problems. A patient would perceive the discussion of a prostate problem as a negative reflection on his virility and relationship with his wife. This was embarrassing for the nurse as well, as discussion of sexual matters between unrelated males and females is not culturally acceptable. The solution was to remove the question from the history form and get an indication of potential prostate problems by asking about problems with urination.

As conveyed by their narratives, values of modesty and dignity are deeply ingrained cultural values where transgressions can have a great personal impact. The following narrative captures the importance of these values and the profound impact of personal loss of dignity. A nursing professor noted that one of her excellent 4th year nursing students had

barely passed in the first three years of nursing school. The student's first experience in the hospital was so traumatic to her feeling of self respect that she was unable to separate the personal from the nursing professional caring view until she had matured personally and professionally. The nursing professor relates:

In her first experience of the hospital, her preceptor took her to a male catheterisation. For two years, her heart pumps every time she enters the hospital for training. She cried everyday that she had to go to clinical ... I told her that the preceptor was not aware of what she was doing. But for her, it was extremely dramatic. She felt degraded. She felt as nothing. She thought that nursing is very degrading and she lived for two years with that feeling. She got to the end of the third year where she had enough maturity and background to understand the difference. She only excelled in her last year. Mistakes like this can really change the future of somebody. I would say to start with the preceptor, who was not sensitive to her student's needs, but the preceptor [a non-Arab] was not aware of the society she's practising in.

I summarised the profound loss of dignity for this student nurse by saying, "it was very traumatic because it broke every value she held." The nursing professor responded, "Exactly, for two years she said, 'I cried every time I had to go to clinic, I felt degraded, I didn't want to do it.' She was doing it mechanically, but she had built a barrier."

Research on protection of dignity for Arab Muslims

The cultural importance of maintaining family honour through respectful behaviour was a theme in transcultural nursing research on caring patterns of Arab Muslim populations. An ethnonursing study on caring patterns of Jordanian women (Miller & Petro-Nustas, 2002) confirmed the importance placed on women maintaining family honour through respectful behaviour, thereby avoiding family shame. Shame brought on a family lasts for generations and influences family connections in the community. In Jordan, honour killing of females for not upholding family honour, described as a way to keep society pure, still exists. The importance of family and the collective meanings of honour was also a caring theme in Luna's (1994) ethnonursing study of Lebanese American Muslims. Kulwicki et al. (2000) noted the impact of failing to maintain modesty on family honour for Arab Americans receiving health care.

Modesty of dress is valued for both males and females.

Conversely, disrobing in public, even in the hospital environment, is considered immodest. Because female purity, chastity, and modesty is held in such high regard by the Arab culture, a women who is physically exposed to a male or has sexual relations outside culturally prescribed norms will bring shame to the family (Kulwicki et al. 2000, p. 35).

In general, the literature on caring for Muslim patients identifies the need to avoid touch between male health workers and female Muslim

patients and the importance of covering to maintain modesty during procedures and examinations. Gender-specific caring is more important in maternity or gynaecological care (Al-Shahri, 2002; Kulwicki et al. 2000; Lawrence & Rozmus, 2001; Luna, 1994; Rashidi & Rajaram, 2001; Sheets & El-Azhary, 1998). Patient expectations for gender-specific caring emerged in Kulwicki et al.'s (2000) study on perceptions, experiences and patterns of health care of Arab Americans. Modesty and embarrassment in exposing one's body to strangers led to gender preference when seeking and accepting health care from male or female providers. The authors noted that gender issues created problems for clinic staff as the system did not value or cater for gender-specific caring modes.

The impact of gender on the caring experience for Arab Muslim immigrant populations was a care pattern that emerged in studies by Fooladi (2003), Kulwicki et al. (2000), Luna (1994) and Wehbe-Alamah (2005). The impact of gender on the caring relationships is less documented, with the exception of Mebrouk's (2004) study. Fooladi (2003) found a gender difference in the emphasis placed on the holistic and spiritual aspects of nursing by Iranian nursing students. In Fooladi's (2003) study, female nursing students emphasised the spiritual nature of nursing, while male nursing students appeared to value the economic aspects. In my study, I specifically looked for but found no gender differences in the expressions and experiences of caring as spiritual action.

The majority of the research focuses on Arab Muslim immigrants in a Western social context, attributing the need for maintaining modesty to cultural values, without linking it to the religious requirements for maintaining chastity and purity. This failure to link the need for modesty to religious values may relate to a lack of understanding about Islam as interpreted through various cultural lenses.

Gender segregation and the image of nursing

Hospitals are one of the few public institutions where gender segregation is not strictly practiced in the Middle East. Nurses' narratives show ways that loss of dignity occurs in some encounters, when either the patient or the nurse perceives a transgression of the line of culturally accepted behaviour. This dynamic has negatively impacted on the image of nursing in the Middle East.

Research on the image of nursing in the Middle East reflects the societal view that nursing is morally corrupting due to mixing of genders in the hospital environment and that the image of nursing would improve by following the Islamic principles of no mixing of genders (Mansour, 1992). Jackson and Gary's (1991) study on attitudes and knowledge of Saudi nationals towards the health system recommended segregation of hospitals into male and female sections as one strategy to increase the number of Saudi nurses. A number of authors agree that separate male and female hospitals would achieve the degree of segregation required by conservative Muslim societies in the Middle East and improve job

satisfaction (El-Gilany & Al-Wehady, 2001; El-Sanabary, 1993; Jackson & Gary, 1991; Mansour, 1992).

My earlier research on Saudi nurse leaders (Lovering, 1996) noted the paradox that society views nursing as an unacceptable occupation for Saudi women, yet prefers same gender health care providers. Historical context explains the negative view of nursing as related to the need for mixing of genders and the potential loss of female dignity and honour for the nurse. A nurse linked cultural values, morality and the image of nursing in the medieval ages by explaining:

I have to protect the culture, religion and my background.

Especially in nursing, society doesn't think that females should go into nursing ... as they think nurses have broken their values and therefore are ethically questionable ... this view is inherited from the medieval ages, when nursing was seen as an inferior profession, and the women were ethically questioned (Lovering, 1996, p. 34).

Summary

Protection of dignity is a cultural caring action by Muslim nurses, based on the need to maintain chastity and family honour, and maintaining the family as the core unit of society and social stability. Nursing codes of conduct and health care regulations mandate the protection of dignity. Female nurses take special responsibility for protection of female chastity, in effect acting as a surrogate for family members protecting the family honour.

Patients have a cultural expectation of care by the same gender; however, complete gender separation is impractical. Instead, variable forms of gender-specific care are given, or care is given by non-Muslim nurses. This may depend on patient preference, availability of resources and importance of preserving the modesty of the patient and nurse.

The activity of nursing requires nurses to interact with patients in ways that cross the religious and cultural rules governing gender interactions. Nurses refer to Rufaidah, the first nurse in Islam, as the example that shows their religion permits nurses to care for opposite gender. However, the shared values of the patients and nurses create some barriers to caring for the opposite gender, such as the use of touch and nonverbal communication and, particularly, when caring involves procedures related to the genital region.

Interpreting narratives of Arab Muslim nurses shows that the protection of dignity is a culturally bound expression of a religious requirement to maintain chastity for all Muslims involved in the health care encounter.

This concludes an extensive description of findings about the nurses' culturally constructed view of health and the ways these beliefs translate into forms of caring. In the following chapters, these findings are placed within a theoretical context and further validated by the development of conceptual diagrams that are co-constructed with participants.

Chapter 8: Cultural Construction of Explanatory Models

Introduction

The premise of this thesis is that nurses' explanatory models derive from their cultural and professional domains. As explained in chapter 4, health is defined as spiritual, physical and psycho-social well-being. Spirituality is central to the belief system, and spiritual needs may take priority over physical needs in a distinctive care pattern.

This chapter reflects on health as defined in Western nursing theory and reflects on the historical development of explanatory models. Similarities and differences between Arab Muslim nurses' concepts of spiritual health and balance are compared to Native American, Eastern and faith-based nursing models. A brief review of research on health meanings of Arab Muslim populations will validate the findings of the nurses' religiously informed explanatory model. The development of a diagram representing the Arab Muslim nurses' explanatory model and presentation of a case study further confirms these findings.

This chapter also presents the case that nurses' professional models of health and healing blend into existing cultural and religious belief systems forming a culturally distinct explanatory health beliefs system. This case is based on the results of this study, Kleinman's model (Kleinman, Eisenberg & Good, 1978; Kleinman, 1980) of professional, folk and popular health sectors and evidence of nurses' health beliefs systems from non-Western health contexts.

Health as defined in Western nursing theory

Health is a central concept and the goal of nursing. It is variously conceptualised as a state, a process, a continuum, an outcome and a style of life (Jones & Meleis, 1993; Meleis, 1990). Saylor (2003, 2004) argues that current health definitions reflect the dualistic Cartesian philosophy underlying the biomedical model and suggests that holistic care should incorporate Eastern traditions of mind-body integration, energy systems and balance. Meleis (1990) suggests that multiple definitions of health are required for the diversity of populations and clinical environments served by nursing, but argues that some aspects of health are universal.

In the 1850s, Florence Nightingale (1992), seen by many as the pioneer nursing theorist, placed health and the environment as central to her nursing theory. The person's health (or illness) was a result of environmental influences. A century later, nursing theorists of the 1970s and 1980s moved from a biomedical perspective of health to a more phenomenologically informed humanist paradigm. These theorists proposed a variety of grand theories and scholars determined that the central concepts of nursing (nursing's meta-paradigm) were: person, environment, health and nursing (Fawcett, 1984).

Thorne's (1993) critical analysis of health belief systems notes that Western beliefs are alone in conceptualising health as a quality that belongs to an individual as health behaviours, illness experiences and nursing actions take place within the socio-cultural context that shapes

their meaning. "One of the most universal aspects of health in most of the world's cultures is its inseparability from the essence of the social fabric ... the individual cannot be fully understood in isolation from his or her community, natural environment and spirit world" (Thorne, 1993, p. 1933).

Within the humanistic paradigm, transcultural nursing theory places the concept of health within the socio-cultural context. Culture prescribes what a person recognises as health, illness or disease and definitions of health and disease are culturally determined (Andrews & Boyle, 2003). Leininger (1991, 1995) links the concept of culturally defined health with performance of social roles and defines health as a consequence. According to Leininger (1995, p.106), health is "a state of well being that is culturally defined, valued, and practiced, and which reflects the ability of the individuals (or groups) to perform their daily role activities in culturally expressed, beneficial, and patterned life ways."

My research supports the transcultural nursing view that definitions of health are culturally constructed (Andrews & Boyle, 2003; Leininger, 1991, 1995, 2002; Thorne, 1993). Muslims have a spiritual obligation to maintain health, which is consistent with achieving health as a socio-cultural obligation.

The centrality of spiritual health distinguishes the explanatory model of Arab Muslim nurses from Western or Eastern nurses' explanatory models. The experiences of caring previously detailed shows how the nurses translate their spiritually informed explanatory model into a form of caring that is distinguished from the caring provided by their non-Arab, non-Muslim colleagues. Most importantly, the notion of spiritual

health as expressed within the Arab Muslim nurse's belief system is a critical concept that is notably absent in the contemporary (Western) nursing theories.

An historical perspective on spiritual health

Historically, the Western worldview had a similar health explanatory model to that of Islam. Spiritual health was an important part of healing where spirituality, health and illness were complementary aspects (Dawson, 1997; Tinley & Kinney, 2007; VanDan, 2004). Healing occurred as an expression of divine action; purification came through suffering, while sickness and death resulted from sin. These beliefs derive from the story of Eden, where sickness, death, pain and suffering flowed from the original sin of Adam (Dawson, 1997). This history of Eden and the resulting explanatory model is shared by the Jewish, Christian and Muslim religions.

The roles of priest and healer combined in many cultures from around 3000 BC in historical contexts such as Egypt, China, India and the early Christian and Jewish societies (Dawson, 1997; VanDan, 2004). Theologians and physicians had identical social and healing roles until recent times (Thorne, 1993). In the past few hundred years, the rise of positivism and the influence of Descartes resulted in separation of body and spirit by medical healers. The focus of health in Western culture turned to a rationalistic approach and this philosophy continues to dominate the approach to health in Western societies (Dawson, 1997).

This separation of mind and body has affected the holistic approach to care in medicine as the integration of the human person has lost its value (Rashidi & Rajaram, 2001). Thorne (1993) notes the institutionalisation of the Western belief system, but questions how well these principles (the rationalistic approach) are enacted in Western health care practice. While spiritual care is no longer part of the physician's role, that of the practice of faith healing by ministers or religious practitioners continues.

Native American and Eastern nursing views of spiritual health

For Arab Muslim nurses, achieving health requires balancing the spiritual, physical and psychological aspects and living life in preparation for the Day of Judgement. The Qur'an and *hadith* (sayings of the Prophet Mohammad PBUH) give direction for maintaining balance, thus the concept of balance is spiritually derived and enacted. This concept of balance and equilibrium has a different focus to that of the contemporary holistic nursing movement and the concepts of balance and harmony expressed by Native American and Eastern (Chinese, Korean) nurses.

There is recent recognition of the need for a more holistic view of health that incorporates Eastern philosophical concepts of harmony and balance into Western approaches in health care. Saylor (2003, 2004) proposes a blend of mind-body integration, energy systems and balance. The holistic health movement supported by the American Holistic Nurses' Association defines health as harmonious balance of body, mind and

spirit in an ever changing environment (Brouse, 1992). However, these holistic approaches to health remain incomplete for Arab Muslims because in their health belief system spiritual wellness is a pre-requisite for balance and health of body and mind.

While the theological basis is different, there is some similarity between Arab Muslim and Native American nurses' views of achieving balance in spiritual, emotional, mental and physical health and harmony within the environment. Illness is a disruption of the harmony and balance, and requires healing. For Native American nurses, the body, mind and spirit are a whole with all components being interdependent (Hunter et al., 2006; Labun & Emblen, 2007; Rogers, 2001; Struthers & Littlejohn, 1999). However, spirituality is not the central aspect of balance for Native Americans and spiritual well being does not have priority over well being of the body and mind.

Arab Muslim nurses' concept of health and balance is also different to that expressed in Eastern philosophy. For Chinese and Korean nurses, health is harmony between the opposing forces of *yin* and *yang* in order to achieve life rhythm. Fate, *inn* (cause) and *ko* (effect) are the main factors that determine health and are the principles that encourage people to do what is good and right. These beliefs about health and healing shape the nurses' caring, as Chinese and Korean nurses are concerned with restoring balance and harmony of the patient's life forces (Chen, 2001, Pang et al. 2004; Shin, 2001) and do not involve a unitary God figure.

Health and faith-based nursing

Given the observed spiritual focus of the Arab Muslim nurse's health belief system, I examined the literature of faith-based nursing for similarities in values about health, illness and healing. Modern (Western) secular nursing emerged from the Christian faith based nursing of the 19th century, where vowed women²⁰ provided nursing care (Nelson, 1997, 2001). I was unable to find literature that articulated a view of health as experienced by these vowed women; however, literature on Parish nursing was found.

Parish nursing is a recently formalised form of nursing that emerged in the United States in the 1980s in Protestant church communities and is practiced in the United States, Korea, parts of Africa, Europe and Australia (Tuck & Wallace, 2000; VanDan, 2004). Parish nursing is rooted in Christian scripture where nurses are members of a religious group's ministerial team who combine nursing expertise with theological concepts (VanDover & Pfeiffer, 2007) to deliver community based care. The goal is to integrate faith and healing and serve as an extension of the church's mission of promoting well being (Tuck & Wallace, 2000). Within this context, health is defined as harmony with self, others, the environment and God (Chase-Ziolek, 1999).

²⁰ Nelson (2001) used the term vowed women to speak collectively about women who separated from the rest of the world to live in a community according to a set of Christian religious precepts. These women include Catholic nuns (sister-nurses), Anglican sisters and Methodist and Lutheran deaconesses.

There is similarity with Arab Muslim nurse's view of health in terms of harmony and balance in life and the focus on the relationship with God/Allah. As explained by Chase-Ziolek (1999), conceptualising the meaning of health in Parish nursing involves understanding Christian tradition and Biblical concepts in health and healing. While the concept is similar, there are theological differences in the concepts of health, forms of healing and the nature of the relationship with God/Allah. The following chapter *Caring: Shared Meanings and Spirituality* explores the similarities and differences in the ways these beliefs inform the caring practices of Arab Muslim and Parish nurses.

Health meanings of Arab Muslim populations

A key finding in this part of the research was the explication of the religiously informed explanatory model, where health beliefs were based on the concept of *tawheed*. This complete integration of the Muslim worldview with health is summarised by Rassool (2000, p. 1476): "Central to Islamic teachings are the connections between knowledge, health, holism, the environment and the 'Oneness of Allah', the unity of God in all spheres of life, death and the hereafter." I turn now to the research on health and care meanings of Arab Muslim populations to validate this finding.

This study shares some common findings on health and illness models in specific Arab Muslim populations with studies by Wehbe-Alamah (2005), Emami et al. (2001), Brook and Omeri (1999), Al-Helwani (2001) and Daly (1995). According to Brook and Omeri (1999) and

Wehbe-Alamah (2005), care is an act of worship derived from the Muslim worldview, and incorporates religious beliefs and practices and actions to care for the person's own health. In her study of Syrian Muslims in the United States, Wehbe-Alamah (2005) highlighted the importance of spiritual health for promoting physical health and illness prevention. Similar to my study, Brook and Omeri (1999), Daly (1995) and Wehbe-Alamah (2005) found that health promotion is valued to maintain good health in order to be able to practice and meet the requirements of their faith. In this worldview, illness is a caring practice from God to erase their sins and avoid punishment in the afterlife (Al-Helwani, 2001; Wehbe-Alamah, 2005). As found with Arab Muslim nurses, a sense of spirituality flowed through the meaning of health expressed by the participants in a study of Iranian Muslim immigrants to Sweden (Emami et al. 2001). In summary, research on Arab Muslim populations validated the health meanings expressed by nurses in my study.

Validation of the Arab Muslim nurses' explanatory model

A series of validation focus groups confirmed the findings of this research. During this process, a diagram evolved to represent an Arab Muslim nurses' explanatory model. Prior to this validation process, the diagram "Ethical decision making approach for nurses in an Islamic predominant health care environment" (Figure 3) was developed as described in the chapter on the Ethical Dimensions of Caring. After using that diagram for discussions on ethical dilemmas with Muslim and non-Muslim nurses, I returned to the Explanatory Models of Health, Illness and

Healing (chapter 4) and created another diagram (Figure 4) to represent the explanatory model of Arab Muslim nurses.

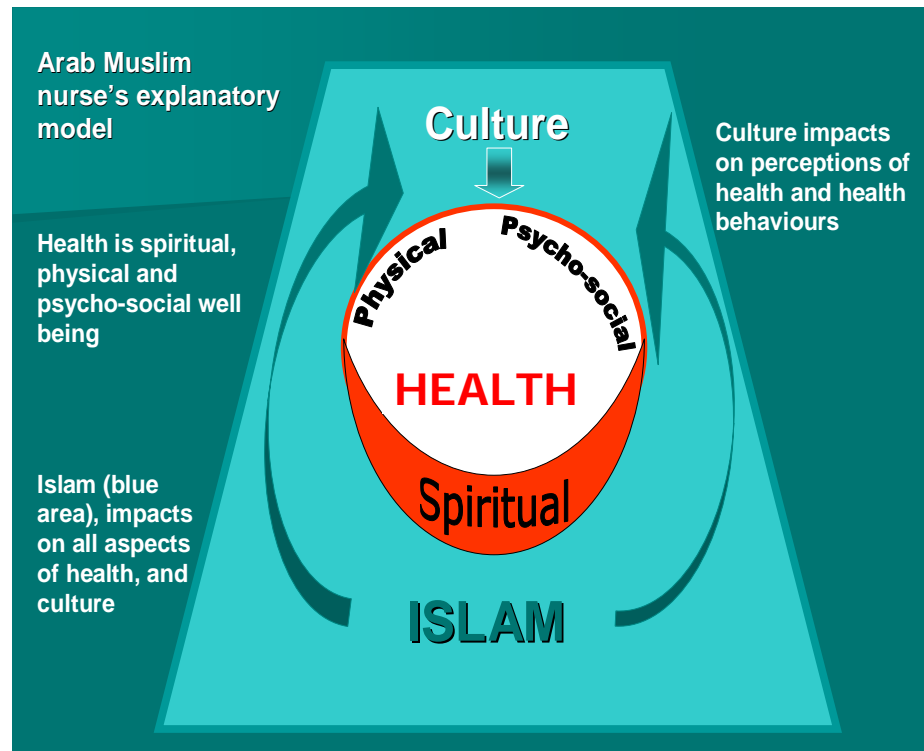


Figure 4. Arab Muslim nurses' explanatory model of health

The centre circle represents the definition of health as spiritual, physical, psycho-social well being. The Red Crescent (a universal symbol of medicine, nursing and health in the Muslim world) symbolises the spiritual aspect of health from which physical and psycho-social well being is derived. The larger font used for "Spiritual" conveys the importance of spiritual well being to health. Similar to the ethical decision making approach diagram (Figure 2), Islam surrounds and impacts on all aspects of health and culture. Culture impacts on perceptions of health and health

behaviours. During validation focus group discussions, the Arab Muslim nurses confirmed that this diagram portrayed the integration of Islam into their health beliefs, components of health and the centrality of spiritual health in their explanatory model.

As part of my conceptualising the interaction between the explanatory model and the components of the nurse caring, Figure 5 (Initial drawing of interaction between the explanatory model and components of nurse caring) was developed. The focus of caring is the patient and family. The nurses' explanatory model is placed in the middle to capture the concept of health as spiritual, physical and psycho-social well being as the basis of the nurses' caring. In this diagram, professional caring includes the technical and interpersonal components that support spiritual caring. While Figure 5 is not the conceptual diagram that eventually emerged as representative of Arab Muslim nurses' caring, I include it here to demonstrate the evolution of the model of caring that emerged from the validation process, showing the incorporation of nurses' explanatory model into nurses' caring models. Further development of the caring model follows in the Caring: Shared Meanings and Spirituality chapter.

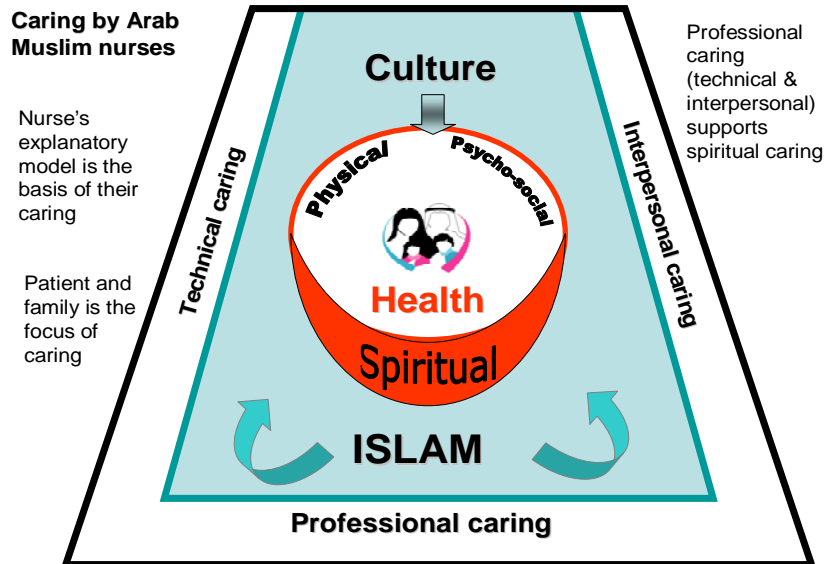


Figure 5. Initial drawing of interaction between the explanatory model and components of nurse caring

A case study

The following case study presented by a Saudi oncology nurse to the ethics panel during a conference session on “Ethical Perspectives at the Bedside” (Al-Swailem & Lovering, 2007) provides an example of how the nurse’s explanatory model guided the nurse’s caring and ethical action. In discussing the case study, the concept of health expressed by the nurse included the spiritual, psychological and physical needs and treating the patient and family as a unit. The impact and interaction of cultural and religious beliefs on health behaviour and the caring experience are shown.

Scenario: A middle-aged Saudi male with multiple myeloma was admitted for pain control and end of life care. He needed large

doses of a morphine infusion to reduce his severe pain and agitation. The family supported the patient psychologically and spiritually through reading of the Qur'an in preparation for death and insisted on optimum pain relief measures. When death seemed imminent, the family asked the team to withhold the morphine infusion so that the patient could communicate to them and give his "living will"²¹ related to family and business matters. The team held the morphine infusion. However, later in the day the family reported that the patient was not alert enough to communicate with them. The morphine infusion was continued and the patient died peacefully the following day.

A conflict between cultural/social values and the view of health as meeting spiritual, physical and psycho-social needs impacted on caring for this patient. The nurse felt that the family's cultural/social needs for the patient to express his living will took precedence over the patient's physical or psychological needs, as discontinuing the morphine led to severe pain and agitation. In her explanatory model, the experience of severe, unnecessary pain led to an inability to meet the patient's spiritual, physical and psychological needs, while meeting the cultural/social needs of the family unit.

In the ethics panel, the Muslim bio-ethics scholar separated the cultural/social and religious aspects that impacted on the care of this and

²¹ The term used by the nurse was "living" will; meaning his directives related to family and business matters. The term in this case should not be confused with the term "living will" in the Western usage that gives advance directives for care at end of life.

similar patients. In Arab culture, the family has a significant influence on the decisions taken by the health care team who treat the family and patient as an integral unit. In this case, the family had a social requirement for the patient to express his wishes concerning family and business issues before his death. From a spiritual/religious view, the patient had a right for relief of his pain “as Allah does not ask us to suffer.” The scholar pointed out that the cultural/social view was incorrect. He noted that “even if there is a need to clear business; it is not applied in this case as it will cause harm to the patient. In Islam, you cannot cause harm to another being.” Therefore, while there is a cultural/social belief directing the care, the religious beliefs take priority.

During the discussion of this case study, Muslim and non-Muslim nurses relayed similar cases where a relative or patient makes a request to withhold pain medication for a spiritual need. Some Muslims wish to pray to Allah with full mental faculties or believe that pain is endured as a way of becoming closer to Allah. The scholar addressed the belief that the patient can become closer to Allah by refusing pain medication. He said, “Some patients believe that if they will suffer, that they will gain from the pain. Allah does not ask us to seek pain. But if you do suffer, you will get reward from Allah.”

In summary, achieving health for patients during end of life care focused on meeting spiritual, physical and psycho-social needs. In this case, the cultural values of the family impacted on the ability of the nurse within the health team to meet these needs. Islam provides the encompassing framework to guide the care of this patient, where the

overriding value is to avoid harm (non-maleficence), and achieve meeting the spiritual aspects of health.

The cultural construction of nurses' explanatory models

Within my Western (biomedically influenced) explanatory model, I expected that Arab Muslim nurses would integrate their religious and cultural values *into* their professional (biomedically influenced) model, given its dominance in the hospital setting where the majority of the nurses worked. Initially I was surprised that religious and cultural beliefs strongly dominated their professional explanatory models. I then recognised that the nurses' professional model must fit within the Islamic worldview as Islam is a complete way of life. In this worldview, predestination determines the presence of disease and effectiveness of medical treatment and other healing. The Western biomedical model of pathology and the science of curing are subject to Allah's will, as is the patient's response to the medical treatment. While Arab Muslim nurses acknowledged the technical aspects of their role (for example talking about their expertise in doing dressings, giving medications, taking care of surgical and intensive care patients), cultural and religious beliefs about health and disease blended and dominated their scientific caring model in a way that makes sense within their culture.

Popular, folk and professional sectors

To understand Arab Muslim nurses' integration of their professional values into their religious and cultural worldview, I return to Kleinman's (1980) work on sectors in an integrated health care cultural system. In any

complex society, there are three overlapping and interconnected sectors: popular, folk and professional. Each sector has a distinct belief system and activities to maintain health, recognise and treat illness, and achieve healing; explanatory models derive from these interconnected yet distinct belief systems (see also Helman, 2001; Kleinman et al. 1978; Thorne, 1993).

In the meaning-centred approach, healing is a transaction across popular, folk and professional belief systems (Good & Good, 1981). Professional, popular and folk models of illness are held concurrently in all cultures (Dein, 2003). The popular sector is the lay, non-specialist domain, usually the family, where health is maintained and illness recognised and treated. Health beliefs and cultural values of the individual and family determine health behaviour. Kleinman et al. (1978) estimated that 70 – 90% of health care in Western and non-Western society takes place within the popular sector. The folk sector is comprised of sacred and secular healers who are not part of the official medical system. These healers share the basic cultural values, health beliefs and worldview of the community (Helman, 2001). In cultures such as Arab Muslim where ill health is attributed to social (e.g., evil eye) or supernatural causes (the will of Allah), sacred healers play an important role in health maintenance and healing within the community. In some countries, such as India and China, the indigenous system of healing (Ayurveda medicine, Traditional Chinese Medicine) has moved from the folk to the professional sector through government sanction. These healing models offer a sanctioned

parallel system of health care to the Western derived biomedical system in these countries (Helman, 2001, Thorne, 1993).

The professional sector is rooted in a secular Western scientific orientation model and includes medical and other health professions, like nurses, who generally focus on recognising and curing diseases of individuals. The professional sector belief system may or may not be compatible with the local culture; however, this belief system is elevated above the other forms of health care (Helman, 2001). According to Helman (2001), as the popular and folk sectors interconnect with the professional (biomedical) sector, health professionals, including nurses, incorporate these culturally determined popular and folk beliefs into their professional practice. Health professionals, however, may not recognise this integration or recognise when there are competing or incompatible value systems. As explained by Thorne (1993, p. 1936), "it seems evident that we Westerners, like the members of all human cultures, are capable of simultaneously holding mutually exclusive and logically incompatible beliefs about health and illness."

In non-Western cultures, there are greater differences between cultural health beliefs and healing traditions and the Western values of the biomedically informed professional system. This may result in an incompatibility between these worldviews and potential for conflict. Within

the context of blending Aboriginal²² and non-Aboriginal health care, Hunter et al. (2006) note that

the reality of living in two distinct worlds — the Aboriginal traditional and the dominant mainstream — is seen as merging to form a new reality, termed a *new middle* (Moss, 2000). The importance of this lies in understanding that centuries of knowledge development are fundamental to traditional ways and that differences in these two worldviews lead to tensions and conflicts. Such differences may lead to misunderstanding between Aboriginal peoples and non-Aboriginal health care practitioners with regards to health practices and spirituality (Moss, 2000).

Blending of professional models into the cultural system

An assumption of this study, based on the medical anthropology view, such as that of Kleinman (1980) and Helman (2001), and contemporary nursing literature, such as Andrews and Boyle (1995), was that professional explanatory models of nurses would incorporate their cultural models of health into their professional model through the process of education and socialisation. As noted by Ketefian and Redman (1997, p. 15), “a Western perspective generally pervades organising concepts and frameworks in nursing and thus is a dominating influence in knowledge development and research. “

²² Hunter et al. (2006) used the term Aboriginal to refer to Native American Indian culture, not Aboriginal culture in Australia.

In reflecting on recent nursing literature from non-Western cultures and the results of my research, I now suggest that the professional view of health and healing is incorporated *into* the nurse's cultural and religious belief system, forming a culturally distinct explanatory health beliefs system adopted in the care of patients. This key finding is validated by research on health and caring by Native American (Hunter et al. 2006; Lowe & Struthers, 2001; Struthers & Littlejohn, 1999), Chinese (Chen, 2001; Pang et al. 2004; Wong & Pang, 2000), Japanese (Hisama, 2001) and Korean (Shin, 2001) nurses that shows this blending of professional values into the indigenous worldview by nurses.

When nurses are socialised into a professional model (whether biomedical or other forms), the professional value system is incorporated into the pre-existing cultural value system in a way that makes sense in the culture. As noted by Native American authors Struthers and Littlejohn (1999, p. 131), "nurses of different ethnic backgrounds potentially have worldviews based on their ethnic origins. This ethnicity influences how values and behaviours are exhibited. Thus, ethnic nurses may perceive life through a different lens and exist differently in the world." If nurses do not blend their professional values into their explanatory model and do not provide care based on the shared value system with their patients, cultural conflict will occur. For example, "when Japanese nurses, who have the same cultural character as their patients, attempt to practice nursing in the Western tradition, they experience many cultural conflicts within themselves and between themselves and their patients" (Hisama, 2001, p. 258).

This blending of professional into traditional cultural worldview emerged in descriptions of the essence of Native American nursing (Lowe & Struthers, 2001; Struthers & Littlejohn, 1999). The concepts of caring, traditions, spirituality, respect, holism, trust and connection reflect a distinct understanding of health for Native American nurses grounded in the Native American worldview. According to Hunter et al. (2006), healing holistically encompasses following a cultural path by regaining culture through healing traditions; regaining balance in the four realms of spiritual, emotional, mental and physical health; and sharing in the circle of life by respectful cultural interactions between Aboriginal²³ peoples and non-Aboriginal health professionals. Native American nurses' distinct explanatory model leads to a culturally informed way of caring, as highlighted by Lowe and Struthers (2001, p. 279), in which Native American nurses "perceive life through a distinct cultural lens and they use this world view to help them make sense of health matters. They thus encounter, experience, and perform the art and science of the nursing profession differently from nurses of other cultures."

Wong and Pang (2000) examined the Chinese concepts of holism, health and caring and found that Chinese nurses articulated beliefs about health and nursing grounded in their cultural belief system, rather than the translated version from the West. In the Chinese nurses' culturally distinct explanatory model, the language used to describe health, illness and healing is "rooted in traditional Chinese medicine and Eastern ideologies"

²³ Noting again that Hunter et al. (2006) use Aboriginal to refer to Native Americans.

(Pang et al. 2004, p. 667). Chen (2001) examined the roots of Chinese values, beliefs and concepts of health to illustrate how those beliefs influence health care and nursing. She concluded that “Chinese philosophies and religions strongly influence the Chinese way of living and thinking about health and health care ... A better way may be to combine both Western and Chinese values into the Chinese health care system by negotiating between the traditional values while at the same time, respecting an individual’s choice” (Chen, 2001, p. 270).

Shin (2001) recognises the importance of using the indigenous culture as the basis for the Korean nurses’ explanatory model. “Although nursing theory has universal aspects, the differences in philosophy and culture that are unique to each country need to be considered ... if nursing science is to be established in Korea, nursing theory development should be based on a Korean understanding of reality” (p. 346) rather than through application of Western nursing theory. Shin (2001) suggests that the Korean nurses’ explanatory model should be based on a holistic view of humans as a micro-universe of *yang* and *yin*; the five elements of earth, wood, fire, metal and water; and the life energy of *khi* (source of life). Shin points out that current Korean nursing education concentrates on the natural sciences rather than the holistic Korean understanding of the human, leading to a gap between practice and nursing theory which is a source of problems in caring.

This study and research on nurses’ beliefs about health and healing in non-Western cultures show the blending of the professional model into the cultural worlds of the nurses in a way that not only makes

sense within the culture but ensures a belief system consistent with that of their patients. These shared systems of meaning form the basis of the nurse-patient relationship and inform caring practice.

Summary

A review of the various Western and non-Western cultural constructions of health in the nursing literature finds a shared historical understanding of health, healing and spirituality between the Muslim, Jewish and Christian religions. Historical changes in Western philosophical thought (often attributed to Descartes) led to a separation of body and spirit for healers and continues to influence the bio-medical approach to healing in the present in Western and non-Western societies (Dawson, 1997; Thorne, 1993). The recent holistic health movement incorporates Eastern philosophical concepts of balance and body-mind integration, challenging the dominant biomedical professional system.

The health beliefs system held by Arab Muslim nurses is distinct when compared with Western-derived nursing concepts of health and non-Western nursing explanatory models as documented by Native American (Hunter et al., 2006; Labun & Emblen, 2007; Rogers, 2001; Struthers & Littlejohn 1999) and Eastern nurses, such as Chinese (Chen, 2001, Pang et al, 2004), Korean (Shin, 2001), and Japanese (Hisama, 2001) nurses. Protestant Christian faith-based nursing incorporates Biblical concepts of health and healing (Chase-Ziolek, 1999; VanDover & Pfeiffer, 2007) and are similar to the Arab Muslim nurse's model emphasising spiritual health and balance.

A review of research examining health beliefs of Arab Muslim populations (Brooke & Omeri, 1999; Daly, 1995; Emami et al. 2001; Wehbe-Alamah, 2005) confirms the centrality of spirituality and that health beliefs are informed by the Muslim worldview, which is further validated by this study. However, neither these nor other studies report the care pattern of spiritual needs before physical needs. This may relate to the lack of research directed at understanding the belief system that informs explanatory models of health.

At the beginning of the study, there was an assumption that professional models of health and forms of healing would be dominant in Arab Muslim nurses' health beliefs models. Limited research on nurse's explanatory models in non-Western societies and the dominance of Western theoretical perspectives in the nursing literature reinforced this assumption (Salas, 2005). The culturally distinct explanatory model expressed by Arab Muslim nurses and a review of literature describing non-Western nursing beliefs of health and healing makes the case that professional models are incorporated into the indigenous worldview of nurses in a way that makes sense within his or her cultural world. This blending ensures that nurses provide care based on a worldview that is culturally appropriate to those receiving nursing care.

Understanding the health beliefs of Arab Muslim nurses contributes to building theory that explains the practice of nursing. As noted by Pang et al. (2004, p. 257), "a theory of nursing derived from nurses' experiences can reflect indigenous practice values and collective understandings in nursing, which in turn can act as a fertile source of

ideas and inventiveness in developing a relevant knowledge base to inform practice.” In the following chapter, Caring: Shared Meanings and Spirituality, caring is considered an act of spirituality, where the outcome of nurses’ caring is spiritual, physical and psycho-social well being, which is the meaning of health in the worldviews of Arab Muslim nurses and patients.

Chapter 9: Caring — Shared Meanings and Spirituality

Introduction

This chapter focuses on caring as an act of shared spirituality. As a beginning, the findings are linked to existing literature on nursing models of caring, such as Leininger (1991, 2002) and Watson (1988a, 1988b). The concept of spirituality is central to this study, so an in-depth view of the past and present place of spirituality in nursing, spiritual care and health outcomes and the nurse's role in spiritual care is given. This builds on the previous discussion (see chapter 8) on the importance of spiritual health as an outcome of care.

The similarities between Arab Muslim nurses' caring and the spiritual expression of caring enacted by nursing nuns and Parish nurses in the context of Christian faith-based caring is examined further. The concept of shared meanings and spirituality is explored through a validation process that led to the development of a conceptual diagram that provides the basis to develop a culture specific model of caring.

Theoretical perspectives of caring

I looked at theories of caring in contemporary nursing literature to find a theory that would be relevant to the models of caring used by Arab Muslim nurses. The main theories of caring with potential relevance are Leininger's theory of culture care (1991, 1995, 2002) and Watson's theory of human care (1988a, 1988b). These theories are from the humanistic approach to caring.

Leininger's theory of culture care

Leininger's theory of culture care (1988, 1991, 1995, 2002) is based on the anthropological view that health and caring are culturally constituted. Leininger (1988, p. 9) defines care as "assistive, supportive, or facilitative acts toward or for another individual or group." The goal is to "provide culturally congruent nursing care as a pathway to health and well being or to help people face disabilities and death" (Leininger, 1995, p. 102).

The findings of my study confirm Leininger's premise that beliefs about health and the expressions, processes and patterns of caring are culture specific. Leininger's theory was used to examine Arab Muslim immigrant culture care meanings in Australia and the United States (Brooke & Omeri, 1999; Luna, 1994; Nahas & Amasheh, 1999; Wehbe-Alamah, 2005). There has been some use of the theory to study populations within a non-Western cultural context, such as care patterns of Jordanian women in Jordan (Miller & Petro-Nustas, 2002), however, the majority of research is focused on immigrant or minority groups within Western cultural contexts.

While acknowledging the anthropological foundation to Leininger's theory, I had a concern that the theory has been developed and tested primarily from a Western nursing value system. Use of the theory generally assumes that the cultural group of interest (persons receiving care) is of a different cultural worldview to that of the researcher, and that

the provider and receiver of care (nurse and patient) have different worldviews.

The epistemological perspective embedded in Leininger's model is that of caring as a human trait (Morse et al. 1990). Leininger's theory provides a framework for describing cultural characteristics of nurses, but does not discover the explanatory models held by the nurses and how these beliefs inform their meaning of caring within a distinct cultural context. Thus, the focus on beliefs and practices is decontextualised from the nurse's ontological and epistemological foundations. For Arab Muslim nurses, the Muslim worldview informs their ontology (or notions of reality) and explanatory models. For Arab Muslim nurses the focus of caring is more than providing culturally congruent care as the nurse and patient share the same meaning system.

The focus of this study was to understand the explanatory models and meaning of caring within a non-Western population in a non-Western context. Using a less prescriptive, but more inclusive, ethnographic methodology was combined with a meaning-centred approach (Good & Good, 1981) to discover the basis of the nurses' explanatory models and how those models integrate with and inform their caring experiences.

Watsons' theory of human care

Watson's theory of human care conceptualises caring as an interpersonal process between two people with transpersonal dimensions. According to Watson (1988a), caring is a moral ideal where the outcome

is protection, enhancement and preservation of human dignity. Watson does not believe that caring is comprised of behavioural tasks, but identified ten carative factors²⁴ that aim toward helping a person maintain or attain a high level of health or die a peaceful death (Watson, 1988a). The philosophical basis of Watson's theory of human care reflects her existential-phenomenological philosophy.

During this study, an Arab Muslim nurse who had completed post graduate nursing study in the United States identified Watson's theory as the nursing model closest to her belief system. This relates to the humanistic focus of the theory and incorporation of spirituality into the carative factors. Watson (1988b) describes caring as the ethical and moral ideal of nursing, which is consistent with Arab Muslim nurses' belief that their caring derives from their Islamic moral system. The key difference between the Arab Muslim nurses' religiously derived caring model and the transpersonal nature of the nurse-patient relationship in Watson's model rests with the existential-phenomenological focus. In Watson's view, transpersonal caring leads to a metaphysical transcending experience between the nurse and patient (Watson, 1988b).

²⁴ The ten factors are: 1) formation of humanistic-altruistic value system; 2) instillation of faith and hope; 3) cultivation of sensitivity to self and others; 4) development of helping-trust relationship; 5) promotion and acceptance of positive and negative expression of feelings; 6) utilisation of scientific problem solving methods for decision making; 7) promotion of interpersonal teaching and learning; 8) provision for supportive, protective and/or corrective mental, physical, socio-cultural, and spiritual environment; 9) assistance with human need gratification; and 10) allowance for existential-phenomenological forces. (Watson, 1988a, p. 62)

Spirituality as defined within the Muslim worldview is inconsistent with the existentialist underpinnings of Watson's model. While explaining how some aspects of Watson's model applied, including the concept of spirituality, the nurse said to me, "something was still missing." I replied to her, "Islam is central to the nurses' caring," and she said, "yes, that is it." This example demonstrates how, for Arab Muslim nurses, the nurse-patient relationship needs to exist within the theological *tawheed* paradigm, where there is unity of Allah in all actions. Existentialism is not congruent with the fundamental concept of *tawheed* in Islam, therefore Watson's model is incomplete for these nurses.

Spirituality in nursing: A review of literature

The healing tradition shared by the three religions (Judaism, Christianity and Islam) places importance on nurses as healers, particularly nurses that blend spirituality as a form of caring, such as Arab Muslim nurses, nursing nuns and parish nurses. The concept of spirituality in Arab Muslim nurses' models of caring needs to be explored in the light of nursing history and the broader discourse on nursing and spirituality in present times. Arab Muslim nurses' spiritual foundation for caring is historically and culturally distinct from the Western nursing tradition. While spirituality was part of the nursing role in both traditions, Western nursing has evolved away from its spiritual foundation towards a secular orientation. The story of Rufaidah as the first Muslim nurse firmly anchors the Muslim nurses' identity and caring in their spiritual roots

where spirituality is an inseparable aspect of their professional and personal identity.

The history of spirituality in Western nursing begins with caring for the sick by deacons in the early Christian churches (VanDan, 2004). Nursing care combined with spiritual care evolved during medieval times (around 500 CE) where monks and nuns provided care in monasteries and abbeys. The spiritual and healing tradition continued in 17th century Europe where spiritual care was part of the nursing role practiced by the nuns (Nelson, 2001). In the mid 1800s, Florence Nightingale, the role model of modern nursing advocated a spiritual dimension within nursing (Chung, Wong & Chan, 2007; Nightingale, 1992; Malinski, 2002; Tinley & Kinney, 2007; VanDan, 2004). Nuns continued to incorporate a spiritual dimension as part of the nursing role until the emergence of the professional nurse in the 20th century saw nursing move from the religious to the secular domain (Nelson, 1997, p. 6). The spiritual aspect of nursing became largely absent in modern nursing as the secular scientific orientation influenced by Cartesian philosophy began to dominate. In the past two decades, the holistic nursing movement has brought renewed interest in the spiritual dimension of nursing by practitioners, scholars and researchers; however, there is a lack of consensus on the definition of spirituality and its place within nursing theory (Chiu, Emblen, VanHofwegen, Sawatzky & Meyerhoff, 2004; Malinski, 2002; Martsolf & Mickley, 1998; McSherry & Ross, 2002).

Some authors contend there is widespread agreement among nursing scholars that spiritual care is a valued and integral component of quality holistic nursing care (Como, 2007; Narayanasamy & Owens, 2001; VanDover & Bacon, 2001). The various spiritual elements discussed by these theorists include: worship as a basic human need; suffering as a spiritual encounter; spirituality as a variable of holism; nurse's role in meeting patient's spiritual needs; patients achieving higher levels of consciousness involving transcendence to a spiritual realm; and religion as an integral component of cultural values (Dyson, Cobb & Forman 1997; Martsof & Mickley, 1998; Tuck, Wallace & Pullen 2001). Others conclude that most nursing theories and models embrace the concept of holistic care and describe individuals as having spiritual needs, but the concept of spirituality and provision of spiritual care is basically ignored (Malinski, 2002; Martsof & Mickley, 1998, Oldnall, 1995).

There are several comprehensive literature reviews of spirituality and nursing, notably Baldacchino and Draper (2001); Chiu, et al. (2004); Dyson, et al. (1997); Larson and Larson (2003); McEwen (2005); Miner-Williams (2006); Ross (2006); and Tanyi (2002). As summarised by McEwen (2005), definitions of spirituality in the nursing literature centre around an individual's essence as a person; a relationship with an infinite being; relationships with others; a search for fulfilment and meaning; and purpose in life. Spirituality intertwines with the mind, body, and emotions. Chiu et al. (2004) reviewed 73 research articles from 1990 to 2000 to develop an ontological and theoretical understanding of spirituality and

found the following themes: existential reality, transcendence, connectedness, and power/force/energy. Chui et al. (2004) concluded that spirituality is a universal human phenomenon, yet confusion and incomprehension of the concept, ambiguity of definition, lack of models and inadequacy of measurement make discussion of spirituality problematic.

There is lack of agreement as to the relationship between religion and spirituality depending on the philosophical and theological perspective. This separation of religion and spirituality in the literature arises from the Judeo-Christian religious tradition, where God is separate from man with the connection made through transcendence (Engbretson, 1996). The concept of transcendence means to exist above and independent of material experience, implying a higher and separate being. Some view religion and spirituality as two separate constructs that are not interchangeable (Dyson, et al. 1997; Malinski, 2002).

Others link religion to culture and society, where religion is a subset of spirituality. Spirituality is “universal and personal ... although spirituality is at the core of all religions, each religion conceptualises spirituality within the parameters of a theological framework, with defined beliefs, rituals and practices” (McEwen, 2005, p. 162). Religion is a social phenomenon that has a spiritual component as well as social and cultural goals and the constructs of religion and spirituality overlap for those people for whom religion is a means of expressing spirituality (Miner-Williams, 2006). Widerquist and Davidhizar (1994, p. 650) note that

“confusion between the terms religion, religious needs, spirituality, spiritual needs and spiritual comfort may contribute to the confusion experienced by nurses.”

A change from the religious focus on spirituality to a more humanistic value system and secularisation of the meaning of spirituality is a recent trend in the nursing literature, which adds further complexity to the definition and understanding of spirituality in nursing (Chiu et al., 2004; McSherry & Draper, 1998). The holistic understanding of spirituality in the nursing context derives almost exclusively from the Christian theological tradition, with a few studies describing spirituality as an alternative perspective to the Western cultural or religious perspective (Chiu et al., 2004; Narayanasamy, 1999). There is little nursing research on spirituality from a cultural perspective, as found by Chiu et al. (2004). In their review of 73 research articles, only 12 concerned a specific cultural group other than the “White” ethnic background, of which two concerned Eastern cultures. There were no studies identified that were concerned with spirituality and Muslim populations. Chiu et al. (2004) recommend that the current understanding of spirituality requires comparative analysis and interpretation across cultures.

This study supports the view of Chiu et al. (2004) that spirituality is culturally constructed. As previously noted, spirituality and religion are inseparable within Muslim culture. Rassool (2000, p. 1480) makes the point that in Islam “there is no distinction between religion and spirituality. The concept of religion is embedded in the umbrella of spirituality. In the

Islamic context, there is no spirituality without religious thoughts and practices, and the religion provides the spiritual path for salvation and a way of life.” This research supports Rassool’s (2000, 2004) contention of the inseparability of religion and spirituality in Islam, as enacted through the caring of Arab Muslim nurses. This inseparability of religion and spirituality contributes to a culturally distinct form of caring by nurses and patients who share the same value system.

Spiritual care and health outcomes

Larson and Larson’s (2003) comprehensive review of quantitative research studies dealing with spirituality and health outcomes found significant links between spirituality, religion and health outcomes. Spirituality or religious practices may provide coping resources, enhance pain management, improve surgical outcomes, protect against depression, and reduce the risk of substance abuse and suicide. Increased poor health outcomes were linked with spiritual distress.

A meta-analysis examining religious involvement found that active religious involvement increased the chance of living longer by 29% (McCullough, Hoyt, Larson, Koenig & Thoresen, 2000) and links with lower rates of depression (Larson & Larson, 2003). Muslim patients receiving psychotherapy with religious content showed significantly more rapid improvement in anxiety symptoms than those receiving traditional therapy with no religious content, thus demonstrating the positive impact of religious care (Azhar, Varma & Dharap, 1994 as cited in Larson &

Larson, 2003). Miner-Williams (2006) notes the reluctance of the Western medical community to acknowledge the correlation between spirituality and positive health outcomes due to the reductionist approach to medical care.

A reflection on the research linking positive health outcomes with spiritual care raises the need for studies to determine the effect of various spiritual caring interventions by Arab Muslim nurses. For example, Arab Muslim nurses working in intensive care described playing recordings of readings from the Qur'an for their comatose patients in their belief that it would relax their patients and promote healing. A study could measure the impact of this caring intervention on the physiological response by Muslim patients. If demonstrated to have a positive impact, Muslim and non-Muslim nurses could use this and other spiritual interventions with Muslim patients.

Nurses and spiritual care

According to Ross (2006), earlier studies found that nurses had limited awareness of patient's spiritual needs, while recent findings (McSherry, 1998; Narayanasamy & Owens, 2001) show nurses are better at identifying and assessing spiritual needs using verbal and non-verbal clues. Nurses perceive spiritual care to be important and valued by patients and say they are willing to provide this care as part of their role. Research suggests that in reality nurses infrequently address spiritual needs and often feel inadequately prepared do so (DiJoseph &

Cavendish, 2005; Narayanasamy, 1993; Ross, 2006; Stranahan, 2001; Tuck et al. 2001). Contributing to the unease in providing spiritual care is the nurses' lack of knowledge about spirituality and religious views, the unclear relationship of spirituality to nursing, lack of comfort with use of existing spiritual assessment tools, limited education on spiritual care within a nursing framework, lack of nursing theories to support spiritual caring and intervention, insufficient time to provide such care and an environment not conducive to spiritual caring (Hoffert, Henshaw & Mvududu, 2007; McSherry & Ross, 2002; Narayanasamy & Owens, 2001; Ross, 1994, 2006).

When spiritual care is given, nurses take a procedural approach by involving others in the care or by arranging for religious rituals and practices (Narayanasamy & Owens, 2001; Ross, 1994, 2006). Other studies suggest that spiritual care is supported when nurses are aware of their own spirituality (Chung, Wong & Chan, 2007), have good links with other professionals such as clergy, adequate staffing and time, have been educated in spiritual care and patients communicate their needs to the staff (Narayanasamy & Owens, 2001; Ross, 1994, 2006; McSherry & Ross, 2002).

Research on the patient's view in a Western health context finds that while patients valued spiritual input from the nurses, they did not expect spiritual caring as part of the nursing role (Ross, 2006), therefore they did not share their spiritual concerns with the nurses (Cavendish et al. 2006). Patients relied more on family and friends for their spiritual

needs. Acceptance of spiritual caring from nurses depended on nurses having adequate time to spend with the patients, as well as spiritual awareness, sensitivity and good communication skills on the part of the nurse (Ross, 2006).

There is much debate in the literature about how, what, where and when nurses should be educated on spiritual care, but there are few studies on the topic. As noted by Ross (2006, p. 860), “there are clear pointers for further research both in identifying the most appropriate and effective approaches to teaching spiritual care to nurses, but also in the assessment of competency in this area.”

Faith-based caring

The previous chapter compared the beliefs about health held by Arab Muslim nurses and faith-based nursing, such as nuns and Parish nurses. In discussions with Muslim nurses and physicians about my research and the integration of spirituality within Arab Muslim nurses' caring, some suggested that similarities may exist with the nature of caring by religious nurses in the Christian religion. I examined the literature (Boggatz & Dassen, 2006; Chase-Ziolek, 1999; Marshall & Wall, 1999; Nelson, 1997, 2001; Tuck & Wallace, 2000; VanDan 2004; VanDover & Pfeiffer, 2007) to gain insight into the nurses' care meanings within a Christian faith-based context. Overall, there were many similarities in the spiritual expression of caring by nursing nuns, Parish and Arab Muslim nurses. I discovered that theological differences of the

relationship between humans and God in Islam (the concept of *tawheed*) and Christianity (God as a transcendent being) exist more from a philosophical perspective than actual spiritual caring practices.

Caring by nuns

There is some literature on the nature of caring by nuns or other vowed women by nurse historians Nelson (1997, 2001), Marshall and Wall (1999) and a recent study by Boggatz and Dassen (2006). This limited literature arises from the lack of acknowledgement in Western nursing history of the religious foundation to secular nursing, as well as the invisibility of religious nursing (Marshall & Wall, 1999; Nelson, 2001).

The values and expressions of caring by nuns are similar to that of Arab Muslim nurses. The spiritual basis of nursing provided by nuns is shaped by the Christian values of obedience to God, the obligation to promote the faith, caring as an expression of morality and care as a form of worship (Boggatz & Dassen, 2006; Marshall & Wall, 1999; Nelson, 1997, 2001). In 19th century England, sickness was an opportunity for Catholic nuns to provide spiritual healing and was an evangelical opportunity. Caring was directed toward the less fortunate of society where a message of cleanliness and godliness was being taken to the poor (Nelson, 1997). Nuns viewed caring as a part of achieving God's mission, a spiritual exercise in obedience and humility, the opportunity to achieve spiritual perfection and receive heavenly reward (Marshall & Wall, 1999; Nelson, 2001). Thus, for the nuns, caring was an act of worship and

ministry. In contrast to Arab Muslim nurses, nuns did not necessarily share the same value system with their patients.

A qualitative study of Coptic Orthodox nuns providing care at a geriatric home in Egypt (Boggatz & Dassen, 2006) provides a more recent insight into the values that underpin caring by nuns. According to Boggatz and Dassen (2006), these nuns experience care as a religious duty to care for the needy and a way of offering one's life to God. Similar to the Arab Muslim nurses, these nuns received God's blessing for caring and expressed this as a direct religious experience. In perceiving care as an expression of Christian morality, the physical aspects of caring (females providing physical care to males), unacceptable within the Egyptian culture, became acceptable. Biblical scripture provides the foundation for their Christian ideal of care (Boggatz & Dassen, 2006).

The work of Boggatz and Dassen (2006) is of particular relevance as the context of caring was the Arab culture, however, the patients and nurses were of the Coptic Christian religion. Boggatz and Dassen (2006) observed the similarities of spirituality as an important dimension of caring for both Coptic Christians and Muslims and raised the issue of the theological differences that underpin the caring experience.

Religious legitimisation of care raises the question of how Muslim caregivers refer to their faith to give a deeper sense to their work ... Nevertheless, the underlying theological concepts might differ, as for the interviewees caring meant to recognise Christ, namely, the son of God, in the elderly, whereas such a perception

contradicts the oneness of God as perceived by Muslims. The impact of such theological differences on nursing practice however requires further investigation. (Boggatz & Dassen, 2006, p.162)

Boggatz and Dassen (2006) suggest the need for empirical comparison between perceptions of Christian and Muslim caregivers on the nature of spirituality in the caring experience. In comparing the results of my study with existing literature on caring by Catholic nuns, I would suggest that there are many similarities between spiritual caring of faith-based nursing in the Muslim and Christian (such as given by nuns) religions. The commonalities are: caring begins with the relationship between the nurse/nun with God; a focus of care is to promote the faith (Islam or Christianity); care is an act of faith and form of worship by the nurse or nun and an opportunity to achieve spiritual perfection; and, in turn, the nurse/nun receives reward from God.

The theological difference raised by Boggatz and Dassen (2006) refers to the concepts of *tawheed* in Islam and transcendence in Christianity. In Islam, *tawheed* means that there is no role for an intermediary between the person and Allah. Religious scholars provide guidance but do not function as a conduit for the person's relationship with Allah. The nurses' role is to facilitate the person's relationship and faith with Allah. In the Christian faith, God is separate from the human so the focus of the faith-based care (as given by nuns) is to act as a conduit between the person and their relationship with God. The clergy (or nun) assists the person's perception of or connection to God's presence,

primarily through the use of prayer (VanDover & Pfeiffer, 2007). Spiritual well being is a component of health, but it is not in a priority over physical and psycho-social well being, unlike Muslim beliefs.

Caring by Parish nurses

Recent research on spiritual care by Parish nurses (VanDover & Pfeiffer, 2007) shows many similarities with spiritual caring by Arab Muslim nurses. VanDover and Pfeiffer (2007) used a grounded theory approach to explain the key elements of spiritual caring by Parish nurses in a context where nurses and patients share a common set of values. VanDover and Pfeiffer (2007) identified the social process of “Bringing God Near” as the substantive theory or process used to provide spiritual care. “Bringing God Near” encompasses five sequential phases: trusting God, forming relationships with the patient or family, opening to God, activating or nurturing faith and recognising spiritual renewal or growth (VanDover & Pfeiffer, 2007, p. 216). Spiritual caring occurs when the nurse assesses spiritual needs in the context of the patient’s health situation and offers spiritual intervention. In “Bringing God Near” the nurse focuses on the patient and God, and the nurse is a conduit or bridge through which the patient or family is transcended into the presence of God (VanDover & Pfeiffer, 2007, p. 216).

For both the Arab Muslim and Parish nurse, the relationship between the nurse and God is the starting point of the process of spiritual caring, and a shared faith and trust in God is the spiritual foundation. As noted by a Parish nurse, “In providing spiritual care, you need to be a

spiritual person yourself or you can't do it ... you really need to keep that relationship with God alive and vital and growing" (VanDover & Pfeiffer, 2007, p. 217).

The Parish nurses activate or nurture the faith of their patients through the use of prayer, physical touch, reading scripture and music. Prayer was the most frequent and important intervention. These spiritual interventions are similar to those used by the Arab Muslim nurses, such as prayer and reading from the Qur'an. The outcome of the Parish nurse's spiritual care is spiritual growth and renewal for the patient and the nurse. The outcome of spiritual caring by Arab Muslim nurses is spiritual well being of the patient and the nurse receiving reward from Allah. For both Arab Muslim and Parish nurses caring is an act of spirituality.

Shared meanings and spirituality

The concept of shared meanings and shared spirituality of the nurse and patient emerged during the validation of my study findings and reflection on the faith-based caring literature. The concept of shared meanings suggests that if the nurse and patient had different faiths, the nurse would not be able to provide effective spiritual caring. VanDover and Pfeiffer (2007, p. 216) noted that "it may be possible for nurses to provide some form of spiritual care without 'Bringing God Near', but this was not evident here." Similarly, when receiving care from a nurse who is not of the same faith, Muslim patients may experience incomplete care and the nurse may find the inability to meet the spiritual needs of the

patient stressful. An example of this is found In Halligan's (2006) study of expatriate non-Muslim critical care nurses caring for Muslim patients in Saudi Arabia. Non-Muslim nurses experienced stress and a sense of powerlessness from their difficulty understanding the religious and cultural aspects of care. "Most of the emotional labour experienced by the nurses was strongly aligned to the aspects of care that are deeply rooted in the patient's religion and culture" (Halligan, 2006, p.1569).

The results of my study and those of VanDover and Pfeiffer (2007) and Halligan (2006) support the view that the nurse and patient need to share the same faith and spirituality to give effective spiritual care. I would argue that given the importance of spiritual well being to achieving health for an Arab Muslim patient, a non-Muslim nurse may be effective in facilitating physical and psycho-social well being, but may lack the shared meanings based on a shared culture and religion to be as effective in providing comprehensive care as a Muslim nurse. The component of spiritual caring may be absent. This concept of shared meanings as a foundation to nurses' caring is developed further in the findings validation process.

Validation of shared meanings: A conceptual diagram

As part of the validation process, I shared three findings chapters (chapters 4, 5 and 7) with several Muslim and non-Muslim colleagues to encourage feedback and debate. I sent these chapters and some of my

diagrams (such as Figures 4 and 5 from chapter 8) to one of my expert insiders, Dr. Sawsan Majali²⁵.

From Chapter 4 (The Meaning of Caring), she drew a series of pictures to show the relationship between the nurses' and the patients' "shared spirituality" that happened during the caring experience. She suggested that there are different levels of interaction or intensity between the spirituality of the nurse and the patient. For example, in an outpatient visit there may be less need for spiritual caring, so the nurses' and patients' spiritual caring is only minimally connected. In episodes of greater spiritual need for the patient, such as during critical illness or with dying patients, there will be a greater sharing of the spirituality. She used her hands to demonstrate this difference. Using cupped hands, she showed her fingers just touching for the outpatient interaction and completely intertwined during the critical illness.

Together, we drew the picture of the linking crescents²⁶, just touching and then overlapping, with the family in the middle. The intertwining of caring and spirituality and shared spirituality between nurses and patient/family is portrayed in Figure 6. The hands inside the caring circle signify the humanistic nature of caring.

²⁵ see acknowledgement, chapter 3.

²⁶ The crescent is a symbol of Islam and spirituality to Muslims.

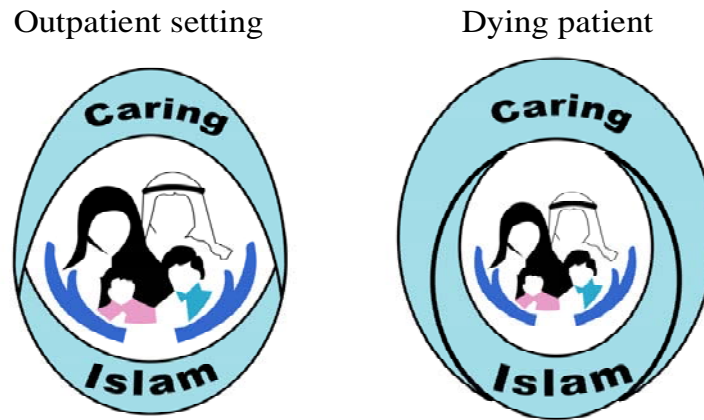


Figure 6. Meaning of caring: Shared spirituality

Subsequent validation focus groups discussed the concept of shared spirituality and different levels of interaction depending on spiritual need. The nurses agreed that there are different levels or intensity of interaction from a spiritual aspect. The blend of the nurse's caring and Islam will depend on the nurse's spirituality, the patient's spirituality, the needs of the patient and whether the patient expects or accepts spiritual caring. It is also fluid, flowing at a time of great spiritual need, such as the time of dying when the caring will enfold the patient and family. Situations where there is expected to be greater spiritual need include the critically ill, during labour and delivery (which is considered a time of life and death), treatment for life threatening or terminal conditions such as oncology patients, or at the end of life. The variable need for spiritual

caring and levels of intensity of shared spirituality led to a discussion of the importance of assessing spiritual needs.

The differences in nurses' and patients' spirituality and the variable needs, expectations and acceptance of spiritual caring highlight variability within this and all cultures. While the nurses and patients share a common cultural and religious belief system, no two people carry the same template of their shared culture. While the core of Arab Muslim nurses' caring is the notion of shared meanings and spirituality, the nature of the shared spirituality as enacted between nurse and patient will remain fluid.

Culture specific nursing theory for education and practice

Western-derived models of care influence nursing education and the health care delivery systems in the Middle East. The Western biomedical model guides health care delivery systems and nurses are predominantly from non-Muslim cultural backgrounds (due to the reliance on a foreign nursing workforce). As previously noted, nursing schools utilise a Western-based nursing curriculum as there is no alternative model of nursing articulated and there is a limited number of nursing texts in Arabic (Al-Darazi, 2003). The majority of nursing faculty have studied their advanced degrees in the West due to limited graduate nursing programs in the region, thus their advanced theoretical background derives from the Western perspective. As previously discussed, the Western nursing curriculum is not congruent with local religious-cultural

views of health (Al-Darazi, 2003). The curriculum and text books promote one model of health and nursing and the belief systems of nursing students, faculty and the patients receiving care are different. The two models co-exist (Western and Islamic health beliefs), however the religious-cultural model dominates, thus maintaining congruence between the value systems of the nurse, patient and the cultural context.

This incongruence between the Western–derived nursing curricula in various Middle East nursing colleges and cultural belief systems was a common concern of Arab Muslim nurses during the study. A nursing academic from Jordan observed that the text books and nursing curricula in Jordan were Western, yet “something was missing from the picture. The model of nursing said one thing, the way we practiced nursing was another.” Another nurse explained that she looked to the nursing history in Islam to “see the connection of who I am as a Muslim.” While practicing, she felt she was lost. She believed that nursing is part of her mission in life, and God gave her the ability to care for others, to teach and to share knowledge. The Western model of nursing gave her the science, but “the human connection was missing.” She felt that the nursing model taught in the nursing school was disconnected from her belief system. “Like in the West, there is a separation of the church and the state, which is not the case for Arab Muslims.”

This study confirms the need for a culture specific theory for Arab Muslim nurses and supports the view that nurses practicing in other non-Western nursing contexts need to develop culture specific theories to

guide the practice and education of nurses. Within some non–Western nursing circles there is recent recognition that “although nursing theory has universal aspects, the differences in philosophy and culture that are unique to each country need to be considered” (Shin, 2001, p. 346). Recognising the importance of culture specific nursing theory to guide practice, Hisama (2001), Shin (2001), Chen (2001), and Pang et al. (2004) have begun to identify nursing theories of relevance to Asian cultures based on their respective cultural belief systems. A similar need to delineate the uniqueness and distinctiveness of Native American nursing led to the identification of seven themes viewed to be the essence of Native American nursing to guide care delivery (Struthers & Littlejohn, 1999).

Arab Muslim nurses’ caring: A picture evolves

When I started this study, I anticipated that the findings could contribute to the development of a culture-specific caring model for Arab Muslim nurses. During the validation process, I drew a series of diagrams to further interpret and integrate the findings into a more cohesive picture of caring. It was not my intention to create what some may call a model of nursing. The process of drawing and redrawing the diagrams with the different groups (hospital nurses and nursing faculty) using the findings and their experiences enabled a rich and more complete perspective to emerge. The final diagram (Figure 7) is not my conceptualisation or interpretation of the nurses’ caring, but that of the Arab Muslim nurses who debated the components of professional caring and values that

shaped their caring experience. The derivation of this final diagram from the findings chapters and subsequent validation focus groups lends credibility to the results.

My first diagram attempted to show the interaction between the explanatory model and the components of the nurse caring (see Figure 5 in the previous chapter). I sent this diagram with the findings chapters to Dr. Majali. Although I intended to capture the spiritual aspect of nurses' caring within the explanatory model, Dr. Majali added spiritual caring to the outer border and redrew the components of professional caring in a circle around the patient. After our discussion on shared spirituality (described earlier in this chapter), we replaced the explanatory model in the middle of the shared spirituality picture (as in Figure 6), and drew the components of caring (technical, interpersonal and spiritual) in a surrounding circle. The validation focus groups further debated these components of caring and the impact of their value systems on their caring experiences.

The final diagram (Figure 7: Arab Muslim nurses' caring) represents the collective view of the meaning of caring as it evolved through refining the drawings during the validation focus group discussions. The first nursing faculty focus group expanded and modified the circle representing the components of caring (technical, interpersonal and spiritual). The term technical care changed to clinical care to be inclusive of physical and technical aspects of care. Psycho-social care was included, which is congruent with their explanatory model of health.

Cultural care was added to recognise the distinct aspects of Arab culture that must be accommodated by nurses, and as distinguished from spiritual care requirements. Over the next three validation focus groups, the outer values circle was created to recognise the impact of spiritual, professional and cultural values as forces impacting on nurse's caring.

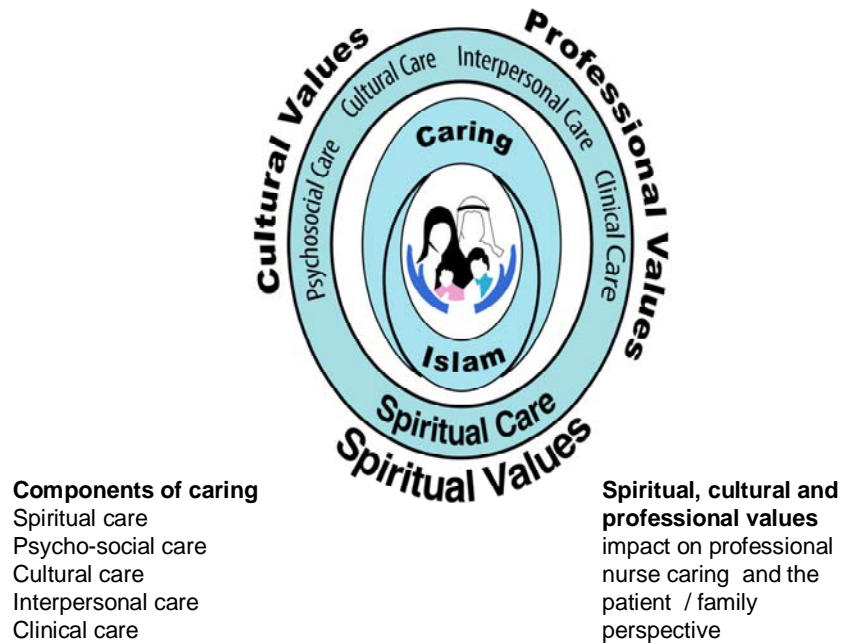


Figure 7. Arab Muslim nurses' caring

There was a point of disagreement within the validation focus groups concerning the font size of spirituality in comparison to the other professional caring components. The debate centred on whether spiritual and clinical caring should be presented as equal in size and, thus, of equal importance or was spiritual care of greater importance. One view held that "if you don't do the technical (clinical) aspects right you could kill the patient," where the other view was that if spiritual care was not

complete, the patient could not have physical health. Subsequent focus groups supported the view that spiritual care is larger, “as with spiritual care you get the honesty and conscience in doing the care, which will take care of the other technical parts.” In the final diagram (Figure 7), spiritual care is larger in size, which is consistent with the findings of this study that place meeting of spiritual before physical needs.

Defining the components of caring

The last validation focus group, comprised of senior nursing faculty holding PhDs in nursing, further developed this picture of caring by suggesting definitions of the components of caring. These definitions are as follows:

Components of professional nurse caring

Spiritual care: actions to meet the spiritual needs of the patient and family

Psycho-social care: actions to meet the psychological and the social needs of the patient and family, e.g., anxiety, family needs

Cultural care: actions to meet the cultural needs (as different from the spiritual needs, or cultural interpretation of religious need), e.g., gender specific caring

Interpersonal care: aspects of care related to the relationship between the nurse and patient, and includes the patterns of communication

Clinical care: includes knowledge and skills related to providing physical care and technical nursing care (technical skills such as dressings, pain relief, injections, taking care of a ventilator)

Values impacting on professional caring

Cultural values: beliefs from the Arab cultural worldview

Professional values: arising from the profession, such as the code of ethics

Spiritual values: values derived from Islam

The validation focus groups discussed the potential use of the diagram of Arab Muslim nurses' caring (Figure 7). The hospital nurses (2 validation groups) believed the diagram would be of value in teaching non-Muslim nurses about caring for Muslim patients. In their working context, over 75% of the nurses caring for the Saudi patients were non-Muslim and lacked understanding of the importance of spiritual and cultural care, which leads to incomplete care. The Arab Muslim nurses also suggested that the diagram could become a model of caring by nurses at the hospital. The nursing faculty (2 validation groups) agreed that the diagram of caring (with all of the elements) is complete for use as a guide for teaching nursing students. They suggested that the next step is to test the concept of the fluid nature of shared spirituality and caring through research. The senior nursing faculty group (the last group to validate the findings) made plans to expand on Figure 7 and the current definitions to develop a model of nursing for Islamic nursing.

Summary

This chapter explored various aspects of spirituality and shared meanings in nursing, particular by Arab Muslim nurses. The inseparability of religion and spirituality contributes to a distinct form of caring by Arab Muslim nurses, which is culturally and historically distinct from the Western nursing tradition.

The current discourse on spirituality in nursing finds a lack of consensus as to definition, its place in nursing theory and the relationship between religion and spirituality (Chiu et al. 2004; Draper & McSherry, 2002; Dyson et al. 1997; Malinski, 2002; Martsolf & Mickely, 1998; Miner-Williams, 2006; Tinley, & Kinney, 2007). The holistic health movement promotes an understanding of spirituality from the Christian theological tradition (Dawson, 1997; Narayanasamy & Owens, 2001; VanDover & Bacon, 2001; VanDover & Pfeiffer, 2007), but there is little research on spirituality from a cultural context, or studies concerned with spirituality and Muslim populations (Chui et al, 2004). Chiu et al. (2004) propose that spirituality is culturally constructed, which is supported by the findings of my study.

Similar to the Arab Muslim nurses' form of caring, spirituality is an integral aspect of Christian faith-based nursing provided by nuns and Parish nurses (Boggatz & Dassen, 2006; Marshall & Wall, 1999; Nelson, 1997, 2001; Van Dover & Pfeiffer, 2007). The basis of the caring relationship with their patient is the shared faith, which gives a shared meaning to the caring relationship. The theological difference between the

Muslim and Christian faith-based nurses concerns the nature of the human relationship with God as a focus of caring action. Recognising the similarities of the Arab Muslim and Christian faith-based nursing reveals the essence of caring as an act of spirituality and raises areas for further examination of similarities and differences.

The concept of shared meanings and shared spirituality is an important finding of this study. The nature and intensity of this shared spirituality within nurses' caring is fluid and will depend on the spiritual need of the patient, the nurses' and patients' own spiritual values and whether the patients expect or accept spiritual caring. The concept of shared meanings and spirituality as experienced by nurses and patients is an area for further investigation.

The collective view of the meaning of caring that evolved during validation resulted in a conceptual diagram (figure 7) where the blending of nurses' caring and Islam is represented by crescents (symbolising health and spirituality) that encircle the patient and family, held by the nurses' caring hands. The components of the nurses' caring are spiritual care, psycho-social care, cultural care, interpersonal care and clinical care. Spiritual, cultural and professional values impact on the caring experience.

A further dimension of the caring experience is the distinct ethical framework that guides Arab Muslim nurses based on principles of Islamic bio-ethics as presented in chapter 6. The principles of maintaining their faith in all caring actions, preserving the sanctity of life, beneficence, non-

malfeasance and justice guide the nurses' moral and ethical decision making. Thus, Islamic bio-ethics informs the meaning of caring within their spiritually derived model.

This understanding of the nature of caring within their culture enables Arab Muslim nurses to articulate their model of caring as the basis for the education and practice of nursing in the Middle East. In addition, the findings can inform the practice of non-Muslim nurses caring for Arab Muslim patients. The significance of this culturally constructed model of caring and recommendations for further development and research are the basis of the concluding chapter.

Chapter 10: Conclusion

Introduction

This final chapter completes the journey of this research. The focus of the journey was to understand Arab Muslim nurses' experiences of caring within the Arab cultural context. This study focused around two distinct yet integrated phenomena: explanatory models and the meaning of caring. The Muslim worldview is the foundation for their caring and their beliefs about health, illness and healing. The seamlessness of their religiously informed health beliefs and professional caring models shows the importance of understanding explanatory models as the basis for nurses' caring in this and other cultural contexts.

This chapter describes the journey taken to reach these findings through reflexive ethnographic methods of data generation, analysis and validation. It discusses the significance of these findings to Arab and non-Arab Muslim nursing communities, contributions to transcultural nursing knowledge and makes recommendations for building on this research.

Journey of the research

The combined methods of Geertz (1973), Fitzgerald (1997) and Davies (1999) guided this ethnography. According to Geertz (1973), the aim in ethnography is to develop thick description that embeds the phenomena within a cultural context. Many narratives, such as the story of the first Muslim nurse, stories about caring experiences, ethical dilemmas and gender-related concerns presented a tapestry of cultural

description. Data generation methods included interviews, conference presentations, focus groups, document review and immersion into the caring experiences of the nurses in the hospital setting. This reflects Fitzgerald's (1997) multi-method ethnographic approach which triangulated multiple data points within the rich description.

Spirituality was a theme that flowed through the data. Ethnographic moments, which are insightful moments that capture the special meaning of a concept or the need to focus further on an idea (Fitzgerald 2006), occurred at key points in the study. These ethnographic moments are presented here to demonstrate the way spirituality became embedded as a phenomenon within the meaning of caring.

The first ethnographic moment: *"I read about nursing from the West, I think about nursing from the East"*, captured the idea that Arab Muslim nurses blend the science of nursing from the Western biomedical model with spiritual and holistic caring from their Muslim worldview. This led to recognition that the Muslim worldview is the foundation to their explanatory model and that the professional view (based on Western nursing science) is incorporated *into* the nurses existing cultural value system.

The next ethnographic moment was the comment *"we are angels in the air."* This comment was symbolic of the nurses' spirituality within their caring and captured the essence of caring as spiritual action.

The *"spiritual needs come before the physical needs"* idea initially came from an internet site on Islam and health and "fit" with other reading

on the importance of spiritual, physical and psychological health for Muslims. During reflexive dialogue, this comment resonated with the nurses and captured their distinct approach to caring. This care pattern was congruent with the developing picture of the centrality of spirituality in caring.

This insight into *“the centrality of Islam in nurses’ caring”* occurred about half way through the study in a discussion on Watson’s nursing model. One of my expert insiders explained that although Watson’s nursing model included an aspect of spirituality, “something was still missing.” We agreed that “Islam is central to the nurses’ caring.” From this point, my analysis and theoretical formulation shifted to placing Islam at the core of caring.

Recognition of the Islamic bio-ethical framework of nurses’ caring was an unintended, yet important finding. Thus, beliefs about health and healing, caring as a spiritual action and an ethical framework derived from Islamic bio-ethics presented an integrated, yet complex, picture of caring that is spiritually grounded.

Davies’ (1999) reflexive approach supported a continuous process of theoretical formulation and validation. The co-construction process resulted in the creation of various diagrams on the nurses’ meaning systems of health and caring representing a higher level of theory building. Creating the diagrams of “Meaning of caring: shared spirituality” (Figure 6) and “Arab Muslim nurses’ caring” (Figure 7) and defining the components of nurses’ caring confirmed the nurses’ distinct form of caring.

Significance of study

This research provides the “missing connection” between Arab Muslim nurses caring models and the Western professional nursing system. It is significant to both Arab Muslim and non-Muslim nursing communities, particularly for those practicing within Arab cultural contexts. As recipients of caring, Arab Muslim patients will benefit from the knowledge gained in this research. The study adds to knowledge of the cultural construction of caring within all cultural contexts and the literature on the spiritual dimension of caring and faith-based nursing.

Arab Muslim nursing community

This study explicated the Arab Muslim nurses’ culturally distinct model of nursing. The need for such a model to be used by Muslim nurses in Islamic societies was identified (AbuGharbieh & Suliman, 1992; Lovering, 1996; Rassool, 2000). However, no research had identified the values and beliefs on which to base this model. Rassool (2000) suggested that a nursing framework for Muslim nurses and patients should synthesise the concept of *tawheed*, the Islamic code of ethics, health behaviour and practices from the Holy Qu’ran and *hadiths*, and the five pillars of the Islamic faith. He coined the term “*Tawheed Paradigm*” (Rassool, 2000, p. 15) for the basis of this nursing framework. My study provides the foundation for development of such a nursing framework as the concepts suggested by Rassool (2000) are present in the results. The diagrams of shared meanings (Figure 6), Arab Muslim nurses’ caring (Figure 7), and identification of the components of professional nurse

caring among Arab Muslim nurses provide a beginning point. The concepts and nursing framework will further evolve through use in nursing curricula and through theory development and research.

Identification of the culturally distinct aspects of caring and the conceptual diagrams (such as Figure 3, 4, 6 and 7) provide a “picture” of caring to guide non-Muslim nurses in caring for Arab Muslim patients in the Middle East. It helps non-Muslim nurses to understand that their professional belief system must be adapted to provide care that is congruent with the beliefs and culture of their patients. These conceptual diagrams provide a common approach that can reduce misunderstanding and conflict between non-Muslim nurses and their Muslim nursing colleagues and patients.

These findings also provide insight into the needs of Arab Muslim patients who are immigrants in non-Arab countries. There is some research on immigrant Arab Muslim populations (Kulwicki, 1996; Kulwicki et al., 2000; Lipson & Meleis, 1985; Luna, 1994; Nahas & Amasheh, 1999; Omeri, 1997) as discussed in the background chapter. These other studies treat spiritual caring as a “factor” for consideration, but do not fully recognise the centrality of Islam to the patient’s belief system and how this is enacted within the health experience. My study highlights the centrality of spirituality and that meeting spiritual needs may be of higher importance than meeting physical needs for these patients.

Although there is some recognition of the cultural construction of ethics (Christakis, 1992; Crigger et al., 2001; Harper, 2006, Tschudin, 2005), the topic of nursing ethics in non-Western cultural contexts has

received little attention. With the exception of Rassool, (2000, 2004), there is no literature to suggest that Muslim nurses may use an ethical framework that is different to the Western rights-based models. This study provides a beginning point for development of an ethical model for Muslim nurses in Arab and other cultural contexts, contributes to knowledge of nursing ethics in a non-Western context and raises areas for further investigation. The ethical decision making model presented in this thesis should be examined in depth to explicate the decision making process used by Arab Muslim nurses. As a starting point, Pang et al.'s (2003) study of Chinese, Japanese and American nurses' perceptions of ethical role responsibilities could be replicated to compare them with Arab Muslim nurses' ethical perspectives.

Cultural construction of caring

This study highlights the importance of understanding the ontology, the beliefs about health, illness and healing, as the basis for nurses' caring. It also adds to knowledge about the cultural construction of caring in a non-Western cultural context and encourages non-Western nurses to understand their own explanatory models, such as the examples from Chinese (Chen, 2001; Pang et al. 2004; Wong & Pang, 2000; Wong et al. 2003), Korean (Shin, 2001) and Native American nurses (Hunter et al. 2006; Struthers & Littlejohn, 1999). Rather than borrowing from Western nursing models as the gold standard, nursing frameworks grounded within distinct cultural systems should be used to educate nurses, to provide nursing care and guide nursing research.

In the Western nursing context, the assumption that caring derives from a common set of beliefs needs reconsideration. As professional models blend into cultural models, there may be more diversity in forms of caring than is presently recognised. Different explanatory models will be more apparent when there is greater difference in the cultural beliefs, such as those held by immigrant nurses. Transcultural nursing research has primarily focused on identifying the care meanings of patient populations of diverse cultures. A greater recognition of the diversity of nurses' caring models will lead to increased insight into the cultural construction of caring by nurses in all cultural contexts.

Spirituality and faith-based caring

Spirituality in the Western nursing paradigm is problematic. As previously discussed, there is lack of agreement as to its definition and place in nursing theory and an unclear relationship between religion and spirituality (Chiu et al., 2004; Draper & McSherry, 2002; Dyson et al., 1997; Malinski, 2002; Martsof & Mickely, 1998; Miner-Williams, 2006; Tinley & Kinney, 2007). Nurses perceive spiritual care to be important, but infrequently address spiritual needs of patients — and patients do not expect nurses to provide such care (Cavendish et al., 2006; McSherry & Ross, 2002; Narayanasamy & Owen, 2001; Ross, 1994, 2006). The results of my study add further to the literature on spirituality in nursing, and a new dimension to the extensive body of knowledge on caring in nursing. These findings also add to the emerging knowledge on faith-based caring, by comparison to research on caring by nursing nuns and

Parish nursing (Boggatz & Dassen, 2006; Marshall & Wall, 1999; Nelson, 1997, 2001; VanDover & Pfeiffer, 2007).

Future directions

This study raises several areas where there is a need to develop knowledge about nurses' caring within Arab Muslim and other cultural contexts. In setting the priority for future directions, efforts should focus on testing and further theoretical development of the Arab Muslim nurses' caring model (Figure 7). This development will occur by sharing the model widely within the Arab Muslim academic and clinical nursing community through publication, regional conferences, curriculum development and encouraging discussion, debate and further research. This model should become the basis of nursing curricula in the region and the model of practice when caring for Arab Muslim patients.

There are several concepts within the caring model (Figure 7) that require further exploration and validation. At the heart of the model is the concept of shared meanings and spirituality. The conditions under which shared spirituality occurs, ways of assessing spiritual need, the capacity of the nurse and patient to enter into a shared meaning experience and the outcomes of this experience are beginning points for investigation. The fluid nature and intensity of shared spirituality raises further areas for inquiry. VanDover and Pfeiffer (2007) suggest that nurses who do not share the same faith and meaning system with the patient are unable to provide effective care. The patient's perceptions of care by Muslim and

non-Muslim nurses should be studied to determine if sharing the same meaning system and spirituality makes nurses' caring more effective.

Within the suggested model, the components of caring and professional values were identified and defined (see chapter 9). These components and professional values (and definitions) need further work to determine consensus as to definition, completeness and the nature of the relationship between concepts.

The outcomes of caring using this model warrant further study. Within the narratives of the nurses in this study, specific actions to promote spiritual caring such as religious readings to relax patients (using earphones with religious readings for critically ill patients, religious tapes for labouring women) were described. The outcome of these actions on the patient's health and healing needs examination. For example, a patient's physiological responses (relaxation response, pain responses) to various spiritual actions could validate the effectiveness of specific forms of spiritual caring. Given the importance of spiritual action suggested in this study, there is a need to determine if the theoretical benefit translates into healing activity.

Extensive research on caring finds that patients and nurses often have different perspectives on caring (Kyle, 1995; Patistea & Siamanta, 1999). The majority of research on the perspectives of Arab Muslim patients was done within a Western cultural context. Research needs to focus on the patients' beliefs about health and caring within the Arab Muslim cultural context and to validate the expectations of the patient for spiritual caring by the nurse.

On a wider level, further inquiry into the meaning of caring in other Muslim cultural contexts, such as Pakistan, Iran, Malaysia or Indonesia would be beneficial. At many points in this study it was difficult to separate religious from cultural values, or those values that were a cultural interpretation of a religious value. Comparative research would determine the extent to which Islam shapes or culture blends within the caring models, or if there were differences between nurses of different Muslim sects, such as Sunni and Shi'a backgrounds.

Through utilisation and a focus on model development and validation, the result will be a framework for nursing that is reflective of and relevant to nursing within the Middle East region. In addition, the model will provide a solid foundation for the nursing identity as grounded in the values of Islam; raise the status of nursing in the region and acceptability within the culture.

Conclusion

This thesis concludes with some reflections. When starting the journey, I expected that Arab culture and Islam were factors that impacted on the nurses' professional caring, but I had limited appreciation of the inseparable nature of religion and culture within their caring. I struggled to understand the concept of *tawheed*, which is the fundamental value in Islam and the key to understanding this inseparability. Once I grasped the concept of *tawheed*, I recognised the importance of shared value systems in the nurse and patient relationship, which underpins the concept of shared meanings and spirituality in my research.

My journey was marked by symbolism. Ethnographic moments marked the evolution of my understanding of the complexity and uniqueness of the nurses' caring. Each narrative shared by nurses added another dimension to this caring picture. The nurses' caring was symbolised by the imagery of nurses as "angels in the air"; and by the verse from the Qur'an (5:32), "if anyone has saved a life, it would be as if he has saved the life of the whole of mankind."

The development of the conceptual diagrams representing the shared meanings (Figure 6) and meaning of caring (Figure 7) was a highlight in the journey. While theorists would call it a process of "co-construction with participants" (Davies, 1999), to me it was a process of shared discovery between the nurses and me, to uncover the distinct forms of caring used by the nurses but not yet articulated. In a way, it was a moment of "shared wisdom" that will be the basis for deeper understanding of the nurses' meaning of caring and ongoing theory development. In appreciation of the importance of this insight, I finish with words from the Qur'an (2:269): "He grants *Hikmah* [Wisdom] to whom He pleases, and he to whom *Hikmah* [Wisdom] is granted is indeed granted abundant good."

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Appendix A

Chronology of data generation and analysis

2003	Development of research proposal; Literature review and ethical approval
Background chapter (literature review) Draft #1 submitted to Primary Supervisor	This chapter became the basis of the conference presentations on “The Context of Caring for Arab Muslim Nurses” (2004a, b, c, d) and a journal article drafted on “The cultural construction of nursing” in 2005
Submission for ethics approval to King Khaled Eye Specialist Hospital Ethics Research Council and Institutional Review Board (August – November)	Approved November 2003
Submission for ethics approval to University of Sydney Human Ethics Committee December 2003	Approved February 2004
2004	Data generation and analysis begins; relocation from Riyadh to Jeddah for work
Conference presentations: “The Context of Caring for Middle Eastern nurses.”	Presentations give an overview of history of nursing in Saudi Arabia, religious and cultural beliefs about health; research on caring experience of immigrant Middle East populations. Data generation from discussions on this and other presentations
Lovering (2004a) Riyadh (March)	
Lovering (2004b) Jeddah (April)	
Lovering (2004c) Riyadh (May)	
Lovering (2004d) Riyadh (May)	
Group discussions (4) and individual interviews (2) April – June	Interviews/group discussions total of 14 participants; interviews taped and transcribed
Ethnographic moments: “I read about nursing from the west, I think about nursing from the east” “We are angels in the air”	These comments occurred during these interviews/group discussions

Relocation to Jeddah to work at King Faisal Specialist Hospital & Research Centre

August 2004

Submission for ethics approval to King Faisal Specialist Hospital & Research Centre – Jeddah Institutional Review Board

Proposal submitted and approved December 2004

2005	Data generation and analysis ongoing
Conference presentation: “A view of Nursing through a Cultural Lens” (Lovering (2005a) Khamis Mushayt, Saudi Arabia (March).	Presentation on cultural construction of nursing; incorporating initial theme of spirituality in Middle Eastern nursing. Data generation from this presentations and other conference presentations.
Ethnographic moment: “The spiritual needs come before the physical needs”.	Tested the concept with the audience, led to extensive discussion.
Conference presentation: “The Context for caring in Middle Eastern nursing” (Lovering 2005b) Muscat, Oman (March).	Data generation from discussions on this and other conference presentations (Al-Osimy, 2005), (Al-Esry, 2005).
Coding of data from first 12 months.	Initial categories developed.
Ongoing participant observation within work setting.	Extensive field notes and reflective journaling.
Drafted paper on Islam and health beliefs.	Analytical writing as tool for reflection and theorising from data.
Drafted paper on the cultural construction of nursing for the nursing journal “Nursing Inquiry”.	Paper based on the background chapter; paper did not get accepted for publication; however the process of writing the article reinforced the notion of nursing as a cultural construction.
Ethnographic moment: “Islam is central to nurses’ caring” from discussion with expert insider (August).	Analysis and theoretical formulation shifts to placing Islam at core of caring rather than an influencing factor.

2006	Data generation and analysis ongoing; consolidation of themes; begin writing of findings chapters
Attended session on Islamic bioethics (Al-Swailem, 2006) (April).	Discussion with Dr. Al-Swailem, Islamic bioethics expert; initial principles of Islamic bioethics identified.
Conference presentation: "The Context for caring in Middle Eastern nursing" (Lovering 2006a) Riyadh (May).	Presentation of emerging themes/findings from research. Data generation from discussions on this and other conference presentations.
Begin writing of findings chapters (First drafts).	Explanatory Model; Meaning of Caring; Cultural Caring – Protection of Dignity.
2007	Validation and presentation of findings; writing and refinement of thesis
Conference presentations: "Arab Muslim nurses' experiences of the meaning of caring" (Lovering, 2007b) (April) and (Lovering, 2007c) (November) and Hospital Grand Rounds (Lovering, 2007d) (November).	Presented results of study to a broader nursing and physician audience. Validation of findings confirmed with conference participants.
Conference presentations: "Nursing Ethics through a Cultural Lens" (Lovering, 2007a) and expert panel discussion on "Ethical Perspectives at the Bedside" (Al-Swailem & Lovering, 2007).	Preparation of the presentation and involvement of nurses in case study discussions led to the findings chapter on Ethical Dimensions of Caring.
Development of the explanatory model (Figure 4), interaction between explanatory model and components of caring (Figure 5) 'shared meanings' concept (Figure 5) and Arab Muslim nurses' caring conceptual diagram (Figure 7).	Development of diagrams outlined in chapters 8 and 9.
Validation focus groups (2 groups of faculty; 2 groups of hospital nurses).	Validation of findings, development/confirmation of the caring conceptual diagram (Figure 6).

Appendix B

Participant Information Sheet and Consent Form



KING KHALED EYE SPECIALIST HOSPITAL

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“ARAB NURSES’ EXPERIENCE OF THE MEANING OF CARING”

PARTICIPANT INFORMATION SHEET AND CONSENT FORM

PARTICIPANT INFORMATION STATEMENT

You are invited to take part in a research study that seeks to understand the meaning of caring as experienced by Arab nurses within the context of Arab culture. The study is based on the view that the role of caring by nurses is derived from their nursing history, socialization during the nurses' professional training and within the context of the nurses' culture. An understanding of the meaning of the caring experience in the Arab culture may contribute to the development of a nursing model that is reflective of Arab cultural and religious values. This knowledge will also contribute to knowledge about nursing in the Middle East. This study is being conducted by Sandy Lovering (RN BScN MBS CTN), Associate Administrator, Nursing Services at King Khaled Eye Specialist Hospital. This research is being conducted to meet the requirements of the Health Sciences Doctorate (HScD) degree at the University of Sydney, Australia, and is conducted under the supervision of Dr. Maureen Fitzgerald, a medical anthropologist in the Faculty of Health Sciences.

Participation in this study is entirely voluntary. You are not obliged to participate and — if you do participate — you can withdraw at any time without penalty or prejudice. If you agree to participate in this study, you will be asked to participate in one or more interview discussions about your experiences in caring for patients within the Arab culture. The initial interview will take 1 – 2 hours. Further interviews may be needed to clarify information. With your permission the interviews will be audio taped and transcribed to provide an accurate record of the interview. You will be provided with a transcription of the interview for review and amendment. If at any time you wish to turn off the tape recorder, this will be done. If you do not want to answer any specific questions, you do not have to. If you do not wish to have the interview tape recorded, I would like to write brief notes at the time by the interviewer. You will be given an opportunity to review the brief and complete interview notes.

Some people may also be asked to participate in a group discussion on the stories of nurses' caring. The purpose of the group discussions will be to build a greater understanding of caring experiences. Participation in a group discussion is also voluntary. The group discussion will not be taped, but the group will be involved in a collaborative process that will allow us to summarize the discussion.

All information about you or anyone you discuss during the interview will be treated as confidential. All records will be kept in secured files. Only Sandy Lovering and her supervisor will have access to any personally identifying information. You will not be identified in any publications or presentations that result from this work.

When you have read this information, Sandy Lovering will discuss it with you and answer any questions you may have. If you have questions at any time, please feel free to contact *her* at 4821234 ext 2013. You may also contact her supervisor, Dr Fitzgerald, in Australia at 61 2 9351 9216. This information sheet is for you to keep.

Any person with concerns or complaints about the conduct of a research study can contact the Research Department at King Khaled Eye Specialist Hospital (4821234 ext 1352) or the Manager for Ethics Administration, University of Sydney on 61 2 9351 4811.

CONSENT TO PARTICIPATE IN STUDY

I have read and understand the Participant Information Statement, and any questions I have asked have been answered to my satisfaction. I understand that my participation is voluntary and I agree to participate in this research, knowing that I may withdraw at any time. I understand that my personal information will remain confidential in any publication of research. I understand that I am to contact Sandy Lovering or her supervisor, Dr. Fitzgerald to answer additional questions. I understand I will not be paid or compensated for my participation in the research study. I have been given a copy of this Participant Information Statement and Consent Form to keep.

Participant's Name:.....

Participant's Signature:.....Date:.....

Researcher Obtaining consent

I verify that I have given the information sheet to the patient.

Researchers Name:

Researcher's SignatureDate:.....