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Research paper

The Crescent of Care: a nursing model to guide the care of Arab Muslim patients

Sandra Lovering RN DHSc CTN-A
Executive Director, Nursing Affairs, King Faisal Specialist Hospital and Research Centre, Jeddah, Saudi Arabia

What is known on this subject

- For Arab Muslim patients, health beliefs and practices are derived from spiritual and cultural values.
- Nursing models derived from the western nursing perspective are not always congruent with the cultural and religious beliefs of Arab Muslim nurses or their patients.

What this paper adds

- The Crescent of Care nursing model provides guidance for meeting the holistic needs of Arab Muslim patients.
- Spiritual, cultural and professional nursing values are used to determine the spiritual, cultural, psychosocial, interpersonal and clinical caring needs of the patient, where the patient and family are the focus of care.

ABSTRACT

The Crescent of Care nursing model is derived from an ethnographic study of the health beliefs and care meanings of Arab Muslim nurses caring for Arab Muslim patients in the Middle East region. This paper presents a detailed explanation of the model as a holistic approach to the spiritual, cultural, psychosocial, interpersonal and clinical caring needs of Arab Muslims within the Middle East region. Professional nursing values are linked to this explanation and combined to create the model. At the heart of the Crescent of Care model are the patient and family as the focus of care, and the concept of shared meanings and spirituality between nurse, patient and family. These are set within a context of psychosocial, cultural, interpersonal, clinical and spiritual elements of care.

As a culturally specific model for Arab Muslim populations, the model can be used to guide nurse education curricula in the Middle East region and improve the image of nursing in the Arab world. The model also serves a more general purpose in providing guidance for the care of Muslim patients in other settings.

Keywords: Arab Muslim patients, caring, Muslim health beliefs, nursing model, transcultural nursing

Introduction

In Saudi Arabia, only 31.8% of nurses are Saudi nationals (Ministry of Health Saudi Arabia, 2010). Consequently, Arab Muslim patients are often nursed by non-Arab non-Muslim staff from a wide range of countries that include the Philippines, India, Malaysia, South Africa, the UK and the USA. Within this multinational nursing workforce, Arab Muslim nurses represent a distinct perspective on care and nursing that is based on the Muslim worldview (Lovering, 2008). This paper is based on a study of this perspective (Lovering, 2008) which examined the ways in which the nurses' cultural beliefs about health, illness and healing blended with their professional values and caring experiences. The findings were used to inform the development of a unique nursing model, the Crescent of Care, which captures the centrality of Islam in Arab Muslim nurses' practice in the care of Arab Muslim patients. The Crescent of Care nursing

model was further developed by a Model Development Group using a collaborative inquiry methodology to identify the core elements and to apply the concepts to nurses' bedside practice at a tertiary hospital in Saudi Arabia. The project was submitted for ethical approval to the King Faisal Specialist Hospital and Research Centre (General Organization) – Jeddah Institutional Review Board (IRB). This board advised that the collaborative inquiry project was not considered to be a research project, so did not require ethical approval. This article presents the elements of the Crescent of Care model and demonstrates application of the model in a clinical practice setting.

Context of nursing in the Middle East

The historical context of nursing in the Middle East pre-dates the era of Florence Nightingale. The first Muslim nurse was Rufaidah Al-Asalmiya, who lived during the time of the Prophet Muhammad (peace be upon him) (PBUH) in the eighth 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 Prophet's (PBUH) mosque and led nurses in caring for the wounded during the time of the Holy Wars (Al-Osimy, 1994; Jan, 1996). The history of Rufaidah and other nurses at this time is recorded in the *Sunnah*, the record of the traditions, sayings and actions of the Prophet (PBUH). The recognition of Rufaidah as the first Muslim nurse and role model is a very recent phenomenon. In traditional Saudi society, nursing was not regarded as a respectable occupation, and it continues to be regarded with considerable ambivalence. To address this situation, Saudi nurses looked to their religion and history to place the nursing role within their religious framework, and this has had a positive impact on the acceptance of nursing as a profession for women (Lovering, 2008).

Arab Muslim nurses have expressed concerns that their nursing education and practice derive from western perspectives, which are not always congruent with the cultural and religious beliefs of Arab Muslim nurses or their patients (Lovering, 2008). There have been calls for a nursing model, based on Arab cultural values and Islamic health beliefs, that is applicable to Muslim nurses and patients in Arab and Islamic societies (Lovering, 2008; Rassool, 2000), to provide direction for nurse education and provision of care to Muslim patients. Such a model could provide the basis for a nursing identity that is congruent within the Arab Muslim culture, and a beginning point for improving the moral status and image of nursing in the Arab world.

Islam: the religion

The Arab Muslim worldview is derived from the religion of Islam. Islam means total submission and obedience to the will of Allah and is a complete way of life (Al-Shahri and Al-Khenaizan 2005; Rassool 2000). The teachings and law of Islam are derived from the Holy Qur'an and the *Sunnah.* The concept of *tawhid* is fundamental in Islam. *Tawhid* means '*the Oneness of Allah*,' and requires that a Muslim lives in a way that reflects unity of mind and body with Allah. *Tawhid* implies that there is no separation of the body from the spiritual dimension of health. Muslims also believe in predestination and life after death, when Allah judges people, on the Day of Judgment, for their earthly deeds.

There are five pillars or foundations of Islam that must be upheld, namely faith (*Iman*), prayer (*Salat*), giving alms (*Zakat*), fasting for self-purification (*Siyam*) and pilgrimage to Mecca (*Hajj*). The profession of faith (*Iman)* is the statement made by the person that he or she believes that there is no other God to worship but Allah, and Muhammad 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 annual giving of alms or *Zakat* is a religious tax that requires a portion of wealth (2.5%) to be given to the needy. 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. Finally, the pilgrimage (*Hajj*) to Mecca in Saudi Arabia is intended for all who are able to take the journey once in their lifetime.

Crescent of Care nursing model

The Crescent of Care nursing model (see Figure 1) illustrates the values that have an impact on the care of Arab Muslim patients and the components of caring action. The aim of nursing care is to restore the health of the patient. In the centre of the model are the patient and family as the focus of care, reflecting the cultural importance of family as the primary social unit in Arab culture. Surrounding this inner circle are the components of professional nursing care, namely spiritual care (actions to meet the spiritual needs of the patient and family), psychosocial care (actions to meet the psychological and social needs of the patient and family), cultural care (actions to meet the cultural needs and support the values, beliefs and traditions of

Figure 1 The Crescent of Care nursing model.

the patient and family), interpersonal care (aspects of care related to the relationship between the nurse and the patient, including patterns of communication) and clinical care (physical and technical nursing care). The crescent, a symbol of Islam, surrounds the components of care and symbolises the inseparability of nurses' caring and Islam. The linking of the crescent of Islam and care components captures the shared spirituality between the nurse and the patient and family. The outer circle identifies the values that have an impact on care, namely spiritual values (derived from Islam), cultural values (derived from the Arab cultural worldview), and professional values (values and standards arising from the nursing profession). These are each related to both the health meanings and behaviours of the patient and the provision of professional nursing care.

Spiritual values and health

In the Muslim worldview, health is defined as complete physical, psychological, social and spiritual well-being (Al-Khayat, 1997). Spiritual health is an essential component of the Muslim health belief model, and Muslims have a spiritual obligation to maintain their health (Mardiyono *et al*, 2011).

The Qur'an provides guidance on caring for health and maintaining the body. Health is seen as a gift or reward from God, and Muslims are required to engage in healthy practices as a duty to care for their bodies. These healthy practices include maintaining cleanliness and personal hygiene, eating healthy food, avoiding forbidden substances that will harm the body and taking exercise and rest (Lovering, 2008; Mardiyono *et al*, 2011; Wehbe-Alamah, 2008). Muslims are also required to maintain a balance and to live a satisfactory life in preparation for the Day of Judgement (Barolia and Karmaliani, 2008).

Illness, suffering and dying are all part of life, and Muslims should face illness and death with patience, meditation and prayer (Al-Shahri, 2002; Rassool, 2004; Wehbe-Alamah, 2008). Illness is considered to be a natural occurrence as well as a test of faith, an 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, but it may enable a person to return to equilibrium in life and greater knowledge of God. Response to medical treatment is considered to be *qadar*, meaning that it is preordained by God (Lovering, 2008). Death is part of the journey to meet Allah, and is a natural and inevitable phenomenon of life's journey. 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 is a continuous thread underpinning the health beliefs and care perspectives of Arab Muslim patients (Lovering, 2008).

Reading of verses from the Qur'an and use of *ruqyah* (Islamic prayer formulas) are healing methods that have been used since the beginning of Islam. Different supplications (religious sayings) are used

in care, for example, during labour and the birth of a baby, to assist in healing, to protect someone's health, before giving medications and at the end of life. Spiritual healing practices include the use of *ZamZam* water (holy water) for taking medication or to bathe a patient. These spiritual caring actions support the patient's belief in God as the Ultimate Healer (Mardiyono *et al*, 2011).

Cultural values

Cultural values that have an impact on the health experience of the patient are derived from the Arab worldview. These values include the centrality of the family unit in society, cultural health beliefs about health, illness and healing, and the importance of maintaining the modesty and dignity of the patient. The values discussed in this article are general in perspective, and traditions will vary in different cultural and social contexts.

Family

In Arab culture, the family rather than the individual is the core of society, with family commitment, honour and unity as central values. Family structure is predominantly patriarchal and based on an extended family system spanning three or more generations. This expanded structure provides stability as well as physical and psychological support, particularly in times of need (Daneshpour, 1998; Dhami and Sheikh, 2008). Arab Muslims sacrifice separateness and individuality to maintain family cohesiveness. Self-image, esteem, security and identity are derived from the family relationships. Problems arise when family members are isolated from family support, during periods of conflict in the family unit, or when personal problems are discussed outside the kinship network because this is considered to bring shame on the family (Daneshpour, 1998).

In Arab culture, respect and esteem increase with age. Elderly parents are respected for their life experiences, wisdom and hierarchical position within the family unit. In general, the parents, spouses, and older children, in descending order, have greater decision-making power than the rest of the relatives (Al-Shahri and Al-Khenanizan, 2005). Children are valued because they provide parents with a higher social status, a purpose in life, and connectedness within the family system. Children are socialised to obey their parents, respect their elders, be loyal to their family, and demonstrate devotion to their parents.

Cultural beliefs about health, illness and healing

The evil eye and jinn

Cultural beliefs provide explanations for disease and illness alongside those offered by medicine and religion. In this context, belief in the *evil eye* as a cause of disease is common in many cultures, including those in parts of Europe, the Middle East and North Africa (Helman, 2001). Belief in the evil eye pre-dates Islam, and there is reference to it 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 who is 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 cultures in the Middle East region, blue beads or a blue stone such as lapis are worn as protection. To cure the effects of the evil eye, a religious person prescribes actions that will always include readings from the Qur'an and Islamic prayer formulas (Al-Jauziyah, 2003).

Belief in the *jinn* as causing illness is another form of blending religion with cultural beliefs. The Qur'an identifies *jinn* as good or bad spirits, and teaches that Allah created humans and the *jinn* to worship Him. It is believed that *jinn* may cause abnormal physical or mental behaviour, and a special religious healer may cure the person by readings from the Qur'an or use of psychology to get rid of the possession (Lovering, 2002).

Traditional medicine

Traditional medicine and folk remedies are used alongside western medicine. Traditional medicine is based on ancient Arabic medicine, and uses a variety of plants, herbs and healing methods. Although modern pharmaceuticals are available, many people, regardless of educational level, depend on herbal remedies, combining these with modern drugs. Common remedies include the use of honey, black cumin seeds, olive oil and dates, with many traditional remedies found in Islamic teachings (Al-Jauziyah, 2003). For example, cupping (*Hijama*) is a pre-Islamic practice that was used in ancient times in China, Egypt, Greece and Rome to treat a range of complaints, from minor aches to chronic conditions. *Hijama*, which means "sucking" in Arabic, is supported as a traditional healing method in Islam. Suction cups are applied to the skin and the air is drawn out to create a vacuum (dry cupping). Alternatively, a small incision may be

made in the skin and suction applied to suck out blood (wet cupping).

Cupping is usually harmless, but some traditional healing methods may cause harm. For example, traditional healers may use cutaneous cautery (referred to as 'arabic burns' or '*Al Kowie*'), in which hot iron rods are applied to the skin. Cautery is generally chosen when conventional medicine has failed or a chronic medical condition exists (Lovering, 2002). The use of cautery is a cultural folk practice that is not supported by the religion (Al-Jauziyah, 2003).

Protection of modesty and dignity

In general, the literature on caring for Arab Muslim patients identifies the importance of covering the body in order to maintain modesty during procedures and examinations, the need to avoid touch between male health workers and female Arab Muslim patients, and expectations of gender separation in some settings (Al-Shahri, 2002; Mebrouk, 2008; Padela and del Pozo, 2011; Salman and Zoucha, 2010). The need to protect modesty and dignity in the healthcare encounter arises from the religious requirement to preserve chastity and purity. *Hijab*, meaning separation, is the Islamic value that underpins expectations of gender-specific caring and gender separation as interpreted through a cultural lens.

Chastity is a fundamental value for both genders, but is of greater significance for women. Sexual relationships outside marriage are prohibited, and the need to protect '*awrah*' (i.e. parts of the body to be covered) is important. For a man, '*awrah*' includes the parts of the body from the navel to the knee, whereas a woman must cover all the parts of her body except her hands and face. There is no religious or cultural requirement for gender separation in all caring encounters. Patient expectations of gender-based caring depend on the degree of conservatism within their culture. Gender-specific caring is more important in maternity or gynaecological care (Al-Shahri, 2002; Padela and del Pozo, 2011). Cultural values with regard to gender have an impact on caring interactions and the use of touch. Islamic teachings restrict or prohibit touching between unrelated males and females in order to prevent immoral behaviour. However, this does not preclude physical contact when there is justification and need (Al-Shahri, 2002; Padela and del Pozo, 2011).

Professional values

Professional values are communicated through codes of conduct and standards of practice to guide the nurse in caring for the patient. In the context of caring for Arab Muslim patients, the Gulf Cooperation Council (GCC) (2001) *Code of Professional Conduct for Nursing* specifies accountability, dignity, privacy and confidentiality as primary values for guiding nursing conduct. The code does not provide specific guidance on the religious and cultural aspects of care, but directs the nurse to place the psychosocial and spiritual needs of the patient and family at the centre of his or her actions.

Components of care

In all nursing models, nursing actions depend on assessing the needs of the patient and then planning, implementing and evaluating appropriate interventions. In the Crescent of Care model, the patient and family are the focus of care. Assessment includes spiritual, cultural, psychosocial, interpersonal and clinical needs. Spiritual, cultural and professional values related to health, illness and healing guide the assessment and subsequent actions, and the aim is to restore the patient's physical, psychological, social and spiritual well-being.

Spiritual care is defined as actions to meet the spiritual needs of the patient and family. The focus of assessment at this point is the patient's and family's beliefs about health, illness and healing in the spiritual context, and the way that these beliefs blend with the western biomedical model. Patients may accept that their illnesses are from Allah and that cure is predestined. However, they have an obligation to seek and accept medical treatment while at the same time receiving support from religious healing practices, such as reading from the Qur'an, prayer and religious supplications (Mardiyono *et al*, 2011).

Support for prayer is a key nursing action. Patients must pray or read the Qur'an before undergoing procedures such as surgical operations or radiology procedures, or receiving treatment for *in-vitro* fertilisation. The nurse facilitates prayer by giving the patient notice of the timing of the procedure, or by delaying the procedure until prayers are completed. The patient may request that the nurse prays for or with the patient regardless of whether or not the nurse shares the same religious beliefs (Lovering, 2008). Patients may need guidance on the direction for prayer (which should be facing Mecca), or on alternative prayer positions if they are unable to kneel. The nurse can also support the patient and family by ensuring that the Qur'an and prayer mat are available in the patient's room. The Qur'an is a holy book, so extreme care must be taken to ensure that no object is placed on the Qur'an, and out of respect, non-Muslims are requested not to touch it.

The use of religious words during nursing care and procedures is another spiritual caring action. Saying the word '*Bismallah*' (in the name of Allah) before performing any procedure, such as starting an intravenous infusion, drawing blood or giving medication, is a caring action that establishes trust and connection between the nurse and patient, irrespective of whether the nurse is Muslim or non-Muslim (Lovering, 2008). Using the words '*Insha' Allah*' (it is Allah's will) reassures the patient that their condition will improve or that the treatment will be effective. Nurses may need to accommodate family requests to use *ZamZam* water, for example, when wiping the body, giving medication or flushing gastric feeding tubes.

Spiritual caring actions are very important during end-of-life care. Reciting the *Shahadah* (the Muslim profession of faith) at the end of life is the most important caring action. Other actions include reading of the Qur'an, wiping the body with *ZamZam* water, and saying special religious supplications.

Cultural care is defined as nursing actions to support the values, beliefs and traditions of the patient and family. Assessment is focused on traditional beliefs related to health, illness and healing, including beliefs about the *evil eye* or *jinn*. The use of traditional healing methods such as herbs, traditional medicines, oil and honey should also be assessed. Skin assessment is important, to identify the use of *hijama* or *cutaneous cautery* healing practices. Some traditional methods, such as wiping or massaging the patient with olive oil, may be accommodated easily, but others, such as the use of honey to treat wounds or the use of traditional medicines, may be harmful. depending on the patient's medical condition. The nurse may need to accommodate the family's request for a religious healer if the family believes that the *evil eye* or *jinn* have caused the patient's illness, or to change the patient's room if it is believed that a *jinn* is present. Acceptable substitutes may be negotiated for certain practices, but it may also be necessary to provide health education to prevent the use of harmful substances.

Protection of modesty is a fundamental cultural caring action. Actions to protect the modesty of the patient include segregation of waiting rooms and clinics, protection of women patients in any potential interaction with men, and ensuring that the '*awrah*' of the patient is covered at all times. An assessment of patient and family expectations of gender-specific caring is essential for matching these with care delivery. In some circumstances, care may have to be planned around same-gender staff if at all possible, or if this cannot be achieved the care plan may have to be altered.

Psychosocial care is directed at determining the structure of the family, identifying the main decision maker, family roles related to the care of the patient and the impact of illness and hospitalisation on the patient's role within the family. This last item is particularly important given the significance of connectedness within the family and the interdependence of family members. Self-image, security and identity are derived from family connectedness. Isolation from the family may contribute to anxiety and stress, so it is crucial to clarify relationships with other family members and family support systems. Family members can assist the nurse in assessing and interpreting the patient's psychosocial needs, level of anxiety and stress, and coping mechanisms. Nurses need to work through the family when providing psychosocial care.

The obligation to visit the patient is a religious and cultural requirement for family members (Al-Shahri, 2002; Lovering, 2008). Failure to visit a sick relative is considered to be a cause of shame. The obligation to visit may include close neighbours who are considered to be part of the family. Support for the visiting is a caring action, with the family in charge of the visiting process. However, support may be needed from the nurse to ensure a balance of psychological support through visiting, and the need for restorative rest.

Interpersonal care concerns aspects of the nurse–patient relationship and includes patterns of verbal and non-verbal communication. Communication through the use of touch and eye contact is affected by cultural values related to gender and the need to maintain modesty, particularly for women. Islamic teachings do not permit unnecessary touching between unrelated adults of opposite gender (Al-Shahri, 2002), and these values have an impact on the use of touch in nursing care. In practice, the assignment of a male nurse to care for a woman patient should be avoided, as a female nurse or adult relative will then have to be present for all interactions. A male nurse may not provide personal care for women patients or carry out procedures such as catheterisation. Although it is more acceptable for female nurses to care for male patients, some male patients may be uncomfortable about touch that is not related to hands-on nursing care. Male catheterisation should be carried out by a male carer. The use of touch between individuals of the same gender is appropriate, and can be used as a caring action.

The need to maintain modesty affects eye contact between people of opposite gender, and needs to be considered when interpreting eye contact and the use of body language in the healthcare encounter. Eye contact between people of opposite gender may be avoided in an effort to maintain the modesty of the woman (whether she is a patient or a nurse) and to show respect.

Clinical care includes the knowledge and skills related to the physical and technical aspects of nursing care. Nurses directly provide technical care to meet the clinical needs of the patient. In some cases, family members will participate in the physical care of the patient to support the activities of daily living under

the guidance of the nurse. Some aspects of clinical nursing care may have to be modified to accommodate spiritual and cultural needs, such as meeting the needs of fasting patients during the holy month of *Ramadan*.

Shared spirituality between nurses and patients

In the study through which the Crescent of Care model was developed, there was evidence of the intertwining of caring and spirituality and the shared spirituality of Arab Muslim nurses, patient and families (Lovering, 2008). This blend of nurses' caring and Islam depends on the nurses' 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 the time of greatest spiritual need, such as the time of dying, labour and delivery (which is considered a time of life and death), treatment for life-threatening or terminal conditions, such as care of oncology patients, and any critical illness, when spiritual caring will enfold the patient and family. Situations of lesser need may occur in an outpatient setting, where the nurses' and patients' spiritual caring is minimally connected. The variable need and levels of intensity of shared spirituality highlight the importance of assessing the spiritual needs. The intertwining of caring and spirituality and shared spirituality between nurses and the patient and family is illustrated in the picture of the linking crescents in Figure 2, as embedded in the Crescent of Care nursing model (Lovering, 2008, p. 204).

Summary

The Crescent of Care nursing model is derived from research on the health beliefs and care meanings of Arab Muslim nurses caring for Arab Muslim patients within the Saudi setting (Lovering, 2008). The model provides a holistic approach to caring for Arab Muslim patients in meeting spiritual, cultural, psychosocial, interpersonal and clinical care needs as derived from spiritual, cultural and professional nursing values. At the heart of the model are the patient and family as the focus of care, and the concept of shared meanings and spirituality between the nurse, the patient and the family.

The Crescent of Care model can guide the care of Muslim patients, whether in Arab cultures, Islamic societies or immigrant Arab Muslim populations. As a culturally specific model for Arab Muslim populations, the model can also guide nursing education curricula in the Gulf States and improve the image of nursing in the Arab world.

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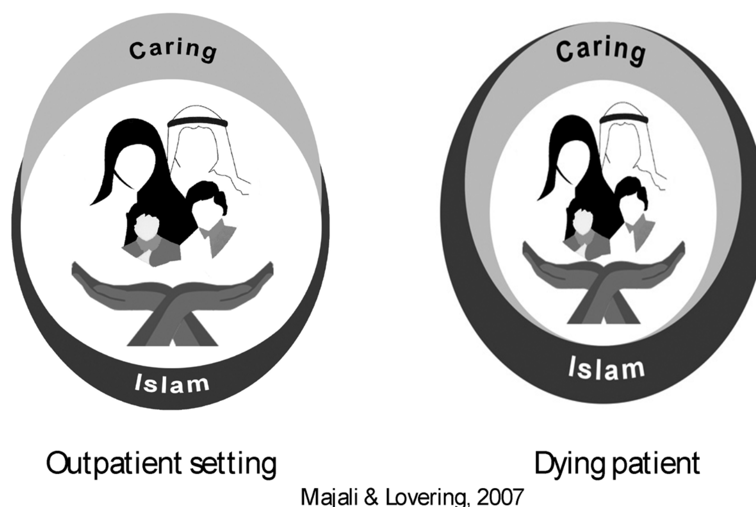

Figure 2 Meaning of caring: shared spirituality.

The author also appreciates and acknowledges the contribution of Dr Sawsan Majali (former Head of the Dar Al Hekma College Nursing Program) in the development of the concept of shared spirituality, and Figure 2 (Meaning of caring: shared spirituality) (Lovering, 2008, p. 204).

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CONFLICTS OF INTEREST

None.

ADDRESS FOR CORRESPONDENCE

Sandra Lovering, Executive Director, Nursing Affairs, King Faisal Specialist Hospital and Research Centre, MBC J73, PO Box 40047, Jeddah 2149, Saudi Arabia. Email: slovering@kfshrc.edu.sa

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