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**Original
Contributions**

CULTURAL COMPETENCIES IN EMERGENCY MEDICINE: CARING FOR MUSLIM-AMERICAN PATIENTS FROM THE MIDDLE EAST

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□ **Abstract—Background:** Cultural competency is crucial to the delivery of optimal medical care. In Emergency Medicine, overcoming cultural barriers is even more important because patients might use the Emergency Department (ED) as their first choice for health care. At least 2.2 million Muslims from Middle Eastern background live in the United States. **Objective:** We wanted to create a succinct guideline for Emergency care providers to overcome cultural barriers in delivering care for this unique population. **Method:** A comprehensive search on medical and health databases was performed and all the articles related to providing healthcare for Muslim-Americans were reviewed. **Result:** The important cultural factors that impact Emergency care delivery to this population include norms of modesty; gender role; the concept of God’s will and its role in health, family structure, prohibition of premarital and extramarital sex; Islamic rituals of praying and fasting; Islamic dietary codes; and rules related to religious cleanliness. **Conclusions:** The Muslim-American community is a fast-growing, understudied population. Cultural awareness is essential for optimal delivery of health care to this minority. We have created a succinct guideline that can be used by Emergency Care providers to overcome cultural barriers. However, it is important to consider the heterogeneity and diversity of this population and to use this guideline on an individual basis. © 2013 Elsevier Inc.

□ **Keywords—**cultural competency; Emergency Medicine; Muslim Americans; Arab Americans

INTRODUCTION

The importance and necessity of cultural awareness in Emergency Medicine has been discussed in several publications (1–6). Defined as “the ability of the health care providers to understand and respond to the unique cultural needs brought by patients to the health care encounter,” this awareness affects diagnosis and treatment and, therefore, is an effective tool to reduce ethnic health disparities (1,3,7,8). Culture includes values, beliefs, customs, and ways of thinking that can impact health care-seeking behaviors, the explanation of disease and its progression, and patient compliance. These beliefs range broadly from disease causation, interpretation of symptoms, and appropriate treatment and prevention, to values attached to medical interventions and physical examination (4,5). It has been concluded that cultural competency should be a part of the training of Emergency Medicine professionals (1,6,9). Some studies have reported health care providers’ belief that “treating patients equally, regardless of their ethnicity and culture” is sufficient (10). However, others called this attitude “cultural blindness,” rather than culturally sensitive care. Culturally sensitive care should address the specific cultural needs of each patient (10,11).

Although communication between the physician and patient is the basis of diagnosis and treatment in any health care system, certain aspects of Emergency Care make it even more critical to emphasize the importance

of the efficacy of communication, both linguistic and cultural. First of all, Emergency Departments (EDs) act as highly specialized “triage centers” and either admit, discharge, or refer patients to clinics. This is especially important for marginalized populations, such as immigrants who might use the ED as the first choice for seeking health care. At this point of entry, the initial communication may dictate the care delivered from there forward. Often, the management initiated in the ED, including the chief complaint, the medication administered, and the diagnosis generated, may not be changed during the hospitalization due to linguistic barriers on a busy medical ward (2).

Second, in critical and highly emergent situations, rapid communication is key to providing optimum care. In this context, the possibility of misunderstanding leading to inefficient care is higher, as there is much less time for communication (2). Furthermore, patient reassurance and trust is another important aspect of cultural communication in Emergency situations, especially for immigrants who may feel unfamiliar in a foreign environment (4).

Studies show that in EDs, racial and ethnic minorities receive lower-quality care, even with equal insurance status and income (5,8). This may be because of stereotyping or communication barriers in the highly stressed environment of the ED. Fortunately, some methods have been proven effective in addressing these concerns and reducing health disparities, including the use of evidence-based clinical guidelines, decreasing tolerance for stereotyping and cultural competence training (2,3,7).

Despite the truth that competence in cross-cultural communication is essential to providing culturally sensitive care, studies show that Emergency Medicine residents are not prepared for providing cross-cultural care; especially when patients’ health beliefs are different from Western values and when religion affects compliance and treatment (5). A substantial percentage of residents believe that they are not able to identify cultural customs that impact medical care (5).

Population: Muslim-American Patients from a Predominantly Middle Eastern Background

It is estimated that 6 to 7 million Muslims live in the United States (US) (3,10,12). The Muslim population is the fastest-growing religious group in the US and Canada (3,10,13). Islam is expected to be the second largest religion in the near future (10). In Canada, the Muslim population is estimated to have increased 207% from 2001 to 2017, reaching 4.5% of the population in 2017, compared with only 1.9% in 2001 (13).

A large proportion of this population are Middle Eastern, a region spanning from Morocco to Iran, including the Persian Gulf region, which consists of three ethnic groups

based on language: Arabs (speaking Arabic), Iranians (speaking Persian or Farsi), and Turks (speaking Turkish) (10,14). Even though people from the Middle East do vary racially and religiously, they share similar values and behaviors (14). In addition, they share these values with Muslims from other ethnic backgrounds as well, such as African Americans and South East Asians (3).

According to the most recent US Census report, the total number of Arabs in the US is 1,573,530; for Iranians it is 439,913, and for Turks it is 189,640 (15). Collectively, this is 2.2 million people. Other studies have proposed the population to be 3.5 million for Arab Americans only (16).

Recent migration data indicate that although Muslim Americans are being integrated into the larger society, they still maintain their culture and religious identity. For instance, in the US, 767,319 people speak Arabic and 349,686 people speak Persian inside their homes (17). For Persians, this number reflects an increase of 226% from 1980; which shows the high rate of immigration of Iranians to the US (17).

Muslim Americans, particularly Middle Easterners, are one of the least studied ethnic groups in the US in terms of health care inequalities, cultural competence, and patient-centered care (3,14). Some studies have mentioned that Muslim Americans are more at risk for heart disease, diabetes, and cancer, due to the lack of access to and use of health care, including the lack of culturally competent services (10,18). One recent study reported better physical health and worse mental health for Arab Americans than the general population of the US (16). Although controversial, it has been suggested that acculturation improves health status in Arab Americans. They are more likely to perceive their health as “poor” if they speak Arabic compared with English-speaking Arab Americans (10,16,18).

SEARCH METHODS

This paper is an attempt to create a succinct and practical descriptive primer for Emergency health care practitioners about issues that should be considered when attempting to deliver culturally sensitive care to Muslim Americans; a heterogeneous group that demonstrates constraints to treatment from a linguistic, ethnic, gender, and social perspective. For this purpose, a comprehensive search using the health databases of PubMed, EMBASE, and Web of Science was performed. In order to ensure inclusion of all relevant studies, the search terms used were broad. These were *cultural sensitive*, *cultural competency*, and *cultural awareness*, also *culture care* plus *Muslim*, *Islam*, or *Arab* anywhere in the title or abstract. In addition, the search was performed with and without key words related to Emergency Medicine, including *Emergency Medicine*, *Emergency Department*,

Emergency Room, and acute medicine. Only English results were included in the paper. After the search, all relevant results were reviewed, their references explored and all articles were obtained and included in the study. Finally, two Google searches were done, one using the same key words to find any relevant Web-based information and another one to find Arab-American, Persian-American, and Turkish-American organizations and the information and sources they provided regarding health care for these populations. No paper was found specifically on the provision of Emergency care in this population. Therefore, we included all articles relating to cultural competencies and health care, read them carefully, extracted, summarized, and organized the information relevant to providing culturally sensitive Emergency care in this population.

Of note, although language and culture are highly inter-related, in this paper we assume that appropriate language translation is provided at the point of care. This guideline may be particularly useful in states like Michigan, California, New York, and Illinois, where large populations of Muslim Americans live (19–21).

DISCUSSION

General Beliefs of Muslim Americans About the US Health Care System

In general, Muslim immigrants find the health care system in the US complicated and confusing. Language barriers; cultural misconceptions; and perceptions of disrespect, discrimination, lack of knowledge about their religious and cultural practices, and gender preferences in seeking and accepting health care are some of the reasons mentioned for this confusion (3,8,10,11). These problems can make patients feel unwelcome in the health care system and delay health care treatment (3). In addition, as a cultural norm arising from modesty and politeness, patients are frequently quiescent, more accepting of the health care hierarchy, and often try to remain unobtrusive. Patients do not verbalize their problem and may expect health care providers to anticipate their needs and situation (10,11).

Although traditional Islamic medicine exists, even in Islamic countries it is considered secondary behind Western medicine and patients may use it when they feel conventional medicine is not accessible or is not working (22,23). They trust in Western medicine, and this is not considered in contrast with belief in God and the healing effects of religious rituals (11,14,19,23). Physicians are held in high regard with great respect and trust, therefore, patients tend to submit to their authority without questioning. As a result, medical litigation cases in Muslim populations occur less often (19). However, other medical staff, such

as nurses, clerks, and social workers, may not be granted the same accord (24).

Qualitative studies have shown that Muslim populations do not consider good health as just the absence of disease, but rather good health is perceived as a state of balance and poor health as a state of imbalance (14,20). Factors such as marital status, physical activity, social support, mental health, and socioeconomic status (poverty) are also important in evaluating self-rated health (14,25). All of these factors can be a part of self-perceived health and a patient may seek to explain them in answering questions by health care providers. In consideration of all these aspects, Middle Easterners may express unclear symptoms, giving generalized and global descriptions of their health status (14).

For medical therapy, patients generally prefer taking pills and injections, and they take these more seriously. If the provider does not prescribe any medicine, the patient may think nothing is being done. Therefore, an explanation about the importance of other kinds of treatment or consultation may be required (14,24). To complicate matters, Middle Easterners are often afraid of hospital admission because hospitals are considered places of bad luck where people go to die (14).

Furthermore, in Muslim culture, politeness, social interaction, and etiquette may be more important than being on time. Therefore, the concept of time may not be as precise as is in the West. For example, 9:30 may mean a time between 9:00 and 10:00 (10,19).

During the provider–patient encounter, the appropriate conversational distance between Middle Easterners is about 2 feet compared with about 5 feet for Americans. This proximity allows them to finely read the other person's reactions in a conversation (14).

God's Will and Fatalism

Muslims frequently refer to God in daily conversations. “Thanks to God” follows statements with positive connotations, including health. “In-sha-allah” (God willing) is used frequently when any plan, wish, or future result is expected; even making an appointment. Both these phrases are conversational and not necessarily religious statements. Rather, they are a sign of being polite and not being assertive about the future (19,20). However, the idea that nothing is performed without the will of God is a major pattern found in different studies. Muslims view health care professionals, religious leaders (Imam), or family members as the “reason” or the mechanism through which help is received. The cure is thought to be from God (12,22).

An early study on sociocultural beliefs of health care reported that the majority of Muslim participants mentioned God as the source of illness and treatment (23,26). Conversely, other mentioned sources for illness

have been the devil, social causes (e.g., evil eye, stress), natural causes (e.g., cold, dirty environment), and hereditary causes (10,12,14).

Despite this, the concept of “God’s will” does not necessarily mean Muslims are fatalistic. Rather, it is a personal responsibility for one to maintain their health and it is expected that one should actively seek help, which is not seen as a conflict in acceptance, rather a submission to the power of God (14,19,20).

Family Structure

Family is the core institution of society in Muslim populations—either nuclear or extended family. Decisions about important issues such as health and treatment are made collectively and all members are usually present at the time of birth, illness, and death. The need for personal relationships is vital and family relations fulfill many affiliation needs. Loyalty to family and respect of the elderly are considered the most important social obligations. Children usually live with parents until marriage (11,14,19). Therefore, a health care provider should build trust with family members, not just with the patient. It is even recommended that health professionals should include a family spokesperson—usually the oldest man present—rather than communicate with the patient only (14). Presence of family members is very supportive and important for patients (10,19). For instance, there are responsibilities for family members to do peri- or postmortem. They may want the patient to say “shahadatan” (testimony of faith) and read the Qur’an over the bed. After death, it is important that all members of the extended family be present during the first hours of funeral rituals. Therefore, a large group of family members may come to the hospital and participate in the grieving process (19).

Gender Role

In Muslim communities, gender is an important factor of identity and social role. It even affects self-reported health; as women are more likely to self-evaluate their health as poor (25). Women, especially married women, bear more burden of the house duties and raising children, and have less time and opportunity for themselves. Therefore, socioeconomic status is a more important predictor of self-perceived health in women compared with men (25). It is also important that health care providers recognize the powerful influence of men in the life of women and attempt to involve them in the treatment process, behavior change, and decision making; whether a father, brother, husband, or religious leader (Imam) (27,28). Although important, this is not an absolute requirement.

Separation of genders is a norm of Muslim societies and, depending on acculturation, contact between male and female may be limited to only family members. Skin to skin contact, even shaking hands between men and women is considered inappropriate and is strongly discouraged, although these rules are relaxed somewhat if medical treatment is required. Female patients may deny physical examination if the health care provider is male (10,24,29–31). One recent study reported gender-concordant care as the most common requested health care accommodation by Muslim Americans, followed by “Halal” food and neutral space for prayer (3). Generally, patients prefer Muslim physicians of the same gender. Their next preference would be a non-Muslim from the same gender, then Muslim physician from opposite gender, and then non-Muslim from the opposite gender (5,31,32). Even having gloves on during a physical examination may help the patient feel more comfortable because it prevents skin to skin contact (5). Cultural norms of modesty include covering of the body for both males and females, particularly for women, who may want to cover their hair and skin according to the rules of “Hijab” (19,31). Therefore, when gender-concordant care is not available, some simple measures, such as asking for permission before entering the patient’s room, can be helpful (3).

Finally, it is worth mentioning that gender norms are increasingly variable and as attitudes are evolving, traditional interpretations of gender roles are evolving as well. This is only an attempt to create an awareness of these issues among Emergency providers.

Sex

Sexual relationship before marriage is considered shameful and strictly prohibited (11,33). Even asking unmarried girls about sexual subjects is sensitive. Rates of premarital and extramarital sex are quite low for Muslim communities and these relationships bring shame to the person and the family (10,19). Therefore, it is recommended that asking about sexual relationships only be done when it is absolutely necessary. In addition, sexually sensitive questions, for instance, about menstruation, should be asked in private, not in the presence of family members, and by providers of the same gender because this can cause extreme shame, discomfort, and distrust (3).

Islamic Rules

Islam, meaning “submission to the will of God” (10), is considered a complete way of life and Muslims believe it gives detailed instruction for any component of life, from praying to washing, eating, dressing, working, family interactions, marriage, birth, and death. Therefore, it is a part of daily life rather than the concept of organized

religion that may be understood in the West (19). For Muslim Americans, the community religious leader, called Imam, can have a key influential role in the patient taking medical advice, changing behavior, or making decisions related to health care (12,28).

The five pillars in Islam are announcement of faith (Shahadatein), praying five times a day, Zakat (giving to the poor), fasting during the month of Ramadan, and Hajj (pilgrimage once in a lifetime) (27). Consideration for ED patients that are directly related to Islamic rules includes prayer, diet, and fasting (19).

Prayer

One of the basic pillars of Islam is praying. Muslims pray five times a day, starting from early morning before sunrise, to late night. For praying, Muslims stand toward Mecca, the holy city in Saudi Arabia. Therefore, patients may ask about the direction toward east. If the patients cannot stand up, they can pray sitting in a chair or bed. Before praying, a Muslim should follow an ablution called "wudu," which includes washing of the face, hands, arms up to the elbows, and feet (19,24). Praying should be in a neutral space (without images or statues) and should not be interrupted, and the person should stand without shoes on a carpet or rug during prayers (3).

The concept of cleanliness is directly related to praying. For praying, body, clothes, and place should be free of "dirtiness," including blood, stool, and urine. Any dirtiness should be washed out by clean water before praying. For this reason, patients usually prefer to go to the bathroom, rather than using a bed pan. A quiet environment should be provided for the patient during prayer, if possible (5,10).

Fasting

Fasting during the month of Ramadan is mandatory in Islam. Islamic calendar is lunar, therefore, the time of Ramadan is variable and can be in any of the four seasons; it is considered more difficult to fast in the summer than the winter due to the heat and longer daylight hours (27). During the prespecified month, Muslims should avoid eating, drinking, smoking, and sexual activity from dawn to dusk. This may include taking medication orally or parenterally. Therefore, patients can request not to take medications and injections during the daytime. Health care providers should be supportive in managing diseases during the fast instead of advising patients against it. Unless the disease condition is such that a fast is detrimental, Muslims are more likely to take the advice if they believe that their health care provider is supportive, understanding, and knowledgeable about this specific religious pillar (19,27). Counseling can help the patient make the

decision and should include information related to the risks and benefits associated with fasting (27).

Generally, Muslims eat a light meal before dawn and a complete meal after sunset. They are exempt from the fast during menstruation, if they are traveling, or if it adversely affects their health, but understand that they may attempt to fast despite their illness (19,27). To elucidate this, a thorough history should include questions about fasting because it can impact the care being provided. Imagine a diabetic on long-acting insulin who becomes hypoglycemic in the ED during the fasting period (19).

Diet

There are specific dietary codes in Islamic law. Not only is consumption of pork and alcohol strictly prohibited in Islam, but they are considered "dirty." Therefore, any medicine that is prepared using products derived from swine or alcohol is also forbidden, e.g., porcine-derived heparin and insulin (19,24). Furthermore, meat should only be consumed if it is "Halal," meaning the animal is killed in a particular way in which all blood is drained out of the body and specific prayers are said before slaughtering. Therefore, patients sometimes ask for vegetarian food although they actually eat meat, and Halal meat should be used for Muslim patients who follow this rule (3,19,24).

CONCLUSIONS

Most of the studies included in this paper were on Arab Americans. However, because of the same cultural background and religion, their results apply to other Muslim Middle Eastern groups like Turks and Iranians and, to some extent, to other Muslim populations in the US (3).

Although Muslim Americans describe a group with a common ethnicity and religion, there is significant heterogeneity in this population from a strict cultural point of view. The Middle East includes >25 countries and cultural backgrounds, access to health care, socioeconomic status, and degree of acculturation can be extremely different even within the people from the same country. In a single country, different religions and ethnic minorities exist. Additionally, cultural norms are always evolving, which makes writing a primer very difficult. However, not considering patient to patient differences can lead to more stereotyping and culturally insensitive care. Therefore, it is very important to remember that universality of cultural guidelines is a misnomer and does not exist. Rather these guidelines can be perceived as generalizations that can and should be applied on an individual basis (11,19).

Limiting factors for this paper include the lack of comprehensive resources for this particular field of study, especially the lack for qualitative research studies that have

prospectively explored the cultural determinants of health in these populations. This prospective research, although recommended, is beyond the scope of this paper.

Although Muslim Americans are a fast-growing population, lack of cultural competent care is a problem that should be addressed with more research and training. Cultural awareness is important for optimal delivery of Emergency health care to this population. We have created a succinct guideline that can be used by Emergency care providers to attempt to overcome cultural barriers, specifically when treating Muslim-American patients. This may lead to the amelioration of health disparities in this population. Emergency Physicians are at the front-line of medicine and are more likely to interact with Muslim Americans. Therefore, this guide will serve as an initial first step in achieving and optimizing the delivery of care.

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ARTICLE SUMMARY

1. Why is this topic important?

Cultural competency is crucial to the delivery of optimal medical care. In Emergency Medicine, overcoming cultural barriers is even more important because patients may use the Emergency Department as their first choice for health care. At least 2.2 million Muslims from Middle Eastern background live in the United States and there is little known about culturally competent care for this population.

2. What does this study attempt to show?

In this paper, we tried to create a succinct guideline for Emergency care providers to overcome cultural barriers in delivering care for this unique population.

3. What are the key findings?

The important cultural factors that impact Emergency care delivery to this population include norms of modesty, gender role, the concept of God's will and its role in health, family structure, prohibition of premarital and extramarital sex, Islamic rituals of praying and fasting, Islamic dietary codes, and rules related to religious cleanliness.

4. How is patient care impacted?

Delivering culturally appropriate care can increase quality of care and reduce health disparities.