The use of Culture Care Theory with Syrian Muslims in the Mid-western United States


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ABSTRACT

Purpose: To discover, describe and analyze the traditional generic (lay, folk, indigenous) and professional care meanings, beliefs, and practices related to health and illness of traditional Syrian Muslims in the Mid-western United States (US).

Design and Research Methods: Leininger’s Culture Care Theory and ethnonursing research method were used for this study. Research participants included 10 key and 20 general informants who ranged between the ages of 18 to 79 years.

Findings: Three themes were discovered: Traditional Syrian Muslim men and women share caregiving responsibilities and practices to promote healthy family and community lifeways; traditional Syrian Muslims view caring for family members, friends, all living creatures, and oneself as embedded in religion; and, traditional Syrian Muslims rely on Islamic spiritual care to promote health and prevent illness.

Conclusion: Providing culturally congruent care is a goal all nurses share or should share. Learning about the generic (lay, folk, or indigenous) care beliefs, expressions, and practices related to health and illness of Syrian Muslims will assist US nurses and other health care professionals to provide this group with culturally meaningful care and lessen cultural pain, clashes, imposition, and conflicts.

Clinical Relevance: Nurses are increasingly caring for patients from cultures other than their own due to increased immigration and diversity within the US. Findings from this study may be used by US health care providers such as registered nurses, nurse practitioners, and others to provide traditional Syrian Muslims with culturally congruent and holistic care.

Key Words: Syrian, Muslims, culture care, ethnonursing, Leininger’s theory, culturally congruent care.

The Syrian Arab Republic lies at the Eastern end of the Mediterranean sea, and is bordered to the North by Turkey, to the East by Iraq, to the South by Jordan, to the Southwest by Israel, and to the West by Lebanon and the Mediterranean Sea (Bateman, 2002).
Present day Syria was once part of a land called Greater Syria, which encompassed Jordan, Lebanon, and Israel in addition to modern Syria (South, 1995). After receiving their independence from the French mandate, people from the regions of Syria and Lebanon immigrating to the US continued to identify themselves as “Syrians” until the 1950’s. The initial impetus for Syrian immigration was the lure of economic opportunity in the US. By 1940, 350,000 persons of Syrian/Lebanese birth were living in the US (Hasser Bennett, 2000). According to the 2004 US Census Bureau Report, the number of people who marked their ethnic origin as "Syrian" on the Census survey in 2000 was 142,897. This figure does not accurately reflect the Syrians living in the US as it does not take into account Syrians identifying themselves as “White” or “Asian” (US Census Bureau, 2004). Data from the 2010 US census for estimated number of Syrians in the US could not be located.

It is estimated that more than 80% of Syrians are Muslims. Christians account for 10% of the population and include Syrian Orthodox, Greek Orthodox, Armenian Orthodox, as well as a few Roman Catholics, Protestants, and Russian Orthodox. An offshoot group of Islam known as the Druze accounts for 3% of the population. There are also small groups of Jews and Yazidis, a sect that combines aspects of Judaism, Christianity, and Islam (South, 1995).

Dr. Madeleine Leininger, who developed the Culture Care Theory and ethnonursing qualitative research method used in this study, contended that by the year 2020, healthcare worldwide will be based on transcultural principles in order to appropriately serve the needs of diverse people (Leininger & McFarland, 2002). Learning about the generic (lay, folk, or indigenous) and professional care meanings, beliefs and practices related to health and illness of traditional Syrian Muslims living in the US will assist nurses and other health care professionals in providing them with culturally congruent care.

**Purpose, Goal, and Domain of Inquiry**

The domain of inquiry for this ethnonursing study was the generic and the professional care meanings, beliefs and practices related to health and illness of Syrian Muslims living in several urban communities in the Midwestern United States. The purpose of this study was to discover, describe and analyze the influences of worldview, cultural context, technological, religious, political, educational, and economic factors on the traditional Syrian Muslims’ generic and professional care meanings, beliefs, and practices. The goal of this study was to provide the nurses with knowledge that can be turned into care actions and decisions that facilitate the provision of culturally congruent care to Syrian Muslims living in urban communities in the Midwestern United States.

**BACKGROUND**

In preparation for this study, the researcher conducted a comprehensive search in the literature regarding the domain of inquiry, involving search engines such as CINAHL, Medline, Google, ArticleFirst, ERIC, FirstSearch, Proquest, and PubMed, and discovered that studies conducted in the US, solely with the Syrian population, were practically nonexistent. However, the author did find a few studies conducted in the US with several Arab cultures, including Syrian (Hammad, & Kysia, 1996; Kulwicki, & Cass, 1994; Rice, & Kulwicki, 1992) as well as a plethora of studies conducted in Syria to investigate numerous medical problems, physical abuse and mental disorders (Alkhatib, Gilthorpe, & McGrath, 2002; Dashdash, 2000; Haidar, 2002; Othman, & Monem, 2001; Maziak, & Asfar, 2003; Maziak, Fouad et al., 2004; and Maziak, Hammal et al., 2004). The synthesis of the literature review revealed a prevalence
of oral health and smoking problems, neoplastic diseases, hepatic problems, Cutaneous Leishmaniasis, and Beta-thalassemia mutations, as well as physical abuse and mental distress involving low-income Syrian women. However, it also identified a dearth of studies conducted in the US with Syrian Muslims as the primary research participants and identified a lack of information in relation to the generic as well as professional care beliefs, attitudes, and practices of this population.

THEORETICAL FRAMEWORK

The theoretical framework for this study was Leininger's theory of Culture Care Diversity and Universality which holds care as the essence and unifying focus of nursing (Leininger, 1991). According to the Culture Care Theory, care is embedded in people's social structure, worldview, language, and environmental context (Leininger, & McFarland, 2006). Cultural diversities and universalities about human care exist among and within all cultures worldwide, and discovering knowledge of them can be used to guide nursing care decisions and actions which will be beneficial to clients' health (Leininger, & McFarland, 2002). When cultural care values, beliefs, expressions, and practices of people of diverse or similar cultures are discovered and used in appropriate, sensitive, and meaningful ways, culturally congruent and therapeutic care occurs (Leininger, & McFarland, 2006).

Ethnonursing Research Method

Leininger's qualitative ethnonursing research method was ideal for this study since it fit well with the Culture Care Theory and with the goal and purpose of this study. Ethnonursing research is an open discovery and naturalistic people-centered research method developed by Leininger with the goal of teasing out complex and largely unknown people's emic (local) viewpoints about nursing dimensions such as human care, wellbeing, health, and environmental influencers (Leininger, & McFarland, 2006). Leininger (1991) stated that a major reason for establishing this method was her interest in discovering the differences and similarities of generic care and professional nursing care among different cultures.

This study took place in several urban

<table>
<thead>
<tr>
<th>INFORMANT’S CODENAME</th>
<th>AGE</th>
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<th>PLACE OF BIRTH</th>
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Table 1: Demographic characteristics of key informants

Midwestern communities over the period of two years in places identified as comfortable by informants, such as homes, mosques, offices, Middle Eastern restaurants and other places of the informants’ choosing. Ten key informants (Table 1) and 20 general informants (Table 2) were interviewed for this study. Informants were recruited using the snowball method as long as they met the following recruitment criteria: 18 years of age or older; born to Syrian parents in any country in the world and then moved to the US or born in the United States to Syrian parents; currently living in the US; stated cultural identity as Syrian Muslim; knowledgeable about the domain of inquiry; and willing to participate in the study. Key informants were considered to be more knowledgeable than general informants about the domain under study and were interviewed on two different occasions. The interviews, which lasted anywhere from 45 minutes to 1.5 hours, consisted of asking semi-structured questions derived from Leininger’s Open-ended Inquiry Guide. Consent

Table 2: Demographic characteristics of general informants
from the Institutional Review Board was secured and a written consent to participate in the study and audio record interviews was obtained from informants.

The use of Leininger’s *Stranger to Friend Enabler* and *Observation-Participation-Reflection Enabler* helped in establishing trust between the researcher and the informants, developing sensitivity to the informants’ verbal and visual clues, and maintaining the researcher’s objectivity during data collection and analysis.

For the purpose of this study, data saturation was reached after interviewing 10 key and 20 general Syrian Muslim informants who ranged between the ages of 18 to 79 years and were knowledgeable about the domain of inquiry. The majority of these informants identified themselves as traditional Syrian Muslims. A written explanation of the study and consent form was read, explained, and given to all informants to sign in either the English or the Arabic language depending on the informant’s individual preference. Informants were given the option of signing their names or leaving a mark on the consent form that was meaningful to them, such as an X, in order to preserve confidentiality. In addition to the semi-structured open-ended inquiry guide and the face-to-face audio taped interviews used in this study. Data was collected through field notes, observation, daily journaling, picture taking of material objects, and videotaping while preserving anonymity.

All audio-tapes were returned to informants following data transcription as is congruent with the Syrian Muslim culture and religion. Rigorous data analysis was conducted through the use of Leininger’s Phases of Ethnonursing Analysis for Qualitative Data, and a software program for qualitative data analysis, called QSR NUD*IST 4. Leininger’s (2006) ethnonursing research evaluation criteria of credibility, confirmability, meaning-in-context, recurrent patterning, saturation, and transferability were used throughout the data analysis.

**MAJOR RESEARCH FINDINGS AND DISCUSSION**

Three major themes were discovered from the data analysis. In the following sections, these themes will be presented with selected patterns and descriptors.

*Theme I-Traditional Syrian Muslim men and women share caregiving responsibilities and practices to promote healthy family and community lifeways*

This universal theme was derived from the informants’ worldview and religious and cultural beliefs, values, and practices and was supported by four patterns and numerous descriptors. Descriptors that supported the pattern of *deriving pride and satisfaction from caring for others* included: “When you care for your family and friends and neighbors, like cooking for them or giving them medications, Allah is pleased with you, and you are pleased with yourself because you pleased God” (K03). Generic care practices that exemplified this pattern included outstanding hospitality, personally caring for elderly relatives at home versus admitting them to nursing homes, extending confidential financial assistance to the needy, offering sick persons chocolates or flowers when visiting them, as well as delivering home-cooked meals and caring for the children of sick community members.

The pattern of *shared care decision-making and practices* reflected some commonalities as well as diversities. While both Syrian Muslim men and women similarly engaged in the provision of emotional and physical care, the men tended to express their care through actions whereas the women tended to be more emotional and verbal in their care expressions. In addition, while both Syrian Muslim men and women engaged in the delivery of physical care, men took pride
in being able to provide financial care for their families and community. Examples of generic care practices included taking time off from work to care for a sick spouse and hiring maids to assist the wife in housework: “My husband shows his caring for me when I am sick by buying food so I don’t have to cook. He also pays for me to have a cleaning lady so I don’t get tired from doing the housework. This is how he demonstrates his caring” (G11).

The pattern of caring as being honest, respectful, tolerant, and accommodating is derived from the Syrian Muslims’ worldview that is embedded in the teachings of Islam. Generic care practices related to this pattern include kissing the right hand of parents and grandparents, refraining from raising the voice when addressing them, accommodating the religious beliefs of others, and being friendly to people of different faiths. The pattern of caring as worrying about others was expressed through the generic care practices of calling or visiting to check on sick people, bringing home-made healthy meals, offering rides to physicians’ offices, developing empathy towards the plight of others and through the delivery of spiritual care, and checking up on the background of future husbands and wives for family members: “We have a system in our community, we check on each other and cook or baby sit for each other when we are sick” (K07).

Interestingly, many key and general informants reported sharing personal left-over medications or providing professional medication samples to individuals who cannot afford the professional services of healthcare providers or purchasing medications as caring actions: “We never bought health insurance because we can always get samples from doctor friends and we can be checked by them for free. We can also call a friend who has the same illness and take left over medications. The only problem is if we need surgery!” (K04). These caring actions were viewed as ways of accommodating the health care needs of others.

In a study conducted by Luna (1989) with Lebanese Muslims in a Midwestern community, it was discovered that care encompassed equal but different gender role responsibilities and that care reflected individual and collective meanings of honor. This theme was also discovered in another study with Lebanese Muslims (Wehbe-Alamah, 2006). These findings are congruent with the theme and patterns of this study which identified care as a source of pride and satisfaction. However, the findings of this study demonstrated that Syrian Muslim men and women reflect more universal caring roles and responsibilities. The discovery that Syrian Muslim men and women engage in similar caring gender roles and responsibilities reflect a difference when compared with findings from earlier studies conducted with Lebanese Muslims (Luna, 1998; Wehbe-Alamah, 2006).

**Theme II- Traditional Syrian Muslims View Caring for Family Members, Friends, all Living Creatures, and Oneself as Embedded in Religion.**

Four care patterns derived from the informants’ worldview, religious and cultural beliefs, values, and practices, and kinship dimensions supported this theme: The universal pattern of care as an act of worship was derived from the worldview and religious beliefs and practices of Syrian Muslims. The majority of informants identified care as an act of worship and maintained that Islam mandates caring for Muslim and non-Muslim family and community members, animals, and oneself: “Caring for family members such as parents, grandparents, siblings, aunts, uncles, as well as unrelated people is a religious obligation” (K09). Syrian Muslims believe that the human body and mind are gifts entrusted to them by God therefore they are required to care for and preserve this trust: “Sleeping is believed to be an act of worship
because it rests and regenerates the body and mind which are two gifts trusted to human beings by God” (K10). Informants shared stories about how the prophet cared for animals and recited verses from the Qur’an that support the belief that caring for all of God’s creatures is a religious duty. Generic care practices that supported this pattern included feeding and being kind to animals, eating healthy foods, going to bed and waking up early, abstaining from actions that are known to be harmful to the body such as smoking, and organizing a schedule for community members to take turns cooking and caring for sick people requiring assistance. Descriptors that gave credibility and confirmability to the researcher’s observations and supported this care pattern included: “When you care for others, you do your Muslim duty” (G01), and “… you are caring when you respect people who are or are not Muslim” (G15).

The pattern of care as family and community unity is derived from the worldview, cultural, religious, and kinship dimensions of Syrian Muslims. Caring for family members, friends, and neighbors fosters unity and cohesion. The social structure of Syrian Muslims is characterized by a close kinship system that is continuously reinforced through caring actions. Syrian Muslims maintain family and community unity through social visitations, phone calls, caring network systems devised at the local community level, caring for elderly parents in their own homes as opposed to sending them to nursing homes, and traveling to visit family members in Syria during the summer to maintain and nurture kinship bonds: “My husband traveled three times to Syria this year to check on his sick mother. He also calls on an almost daily basis. If he doesn’t he would not be considered caring” (K04).

Another pattern that supports theme two is that care is being respectful, tolerant, and accommodating of others. This pattern is embedded in the worldview and religious beliefs and practices of Syrian Muslims and was previously discussed. The pattern of care as worrying about others visited under the first theme was also reflected in the second theme. Caring expressed through worrying about others was found to be embedded in Islam. Islam’s emphasis on fostering family and community unity and on caring for relatives and strangers promotes a feeling of solidarity and responsibility towards others in need: “By caring for community members and neighbors the way we do, we become family, a big family” (K10).

The theme of caring for family members, friends, all living creatures, and oneself as embedded in Islam was also found in a previous study conducted with Lebanese Muslims in the Midwestern US which found that Lebanese Muslims considered caring in general as a religious duty (Wehbe-Alamah, 1999). This theme was also identified by Luna (1989) who discovered that Lebanese Muslims’ family obligations to care were embedded in the religious worldview of Islam.

**Theme III: Traditional Syrian Muslims Rely on Islamic Spiritual Care to Promote Health and Prevent Illness**

This theme was supported by four patterns derived from the worldview and cultural and religious dimensions of Syrian Muslims: The pattern of abstaining from non-caring actions according to Islam as preventing illnesses was supported by the Syrian Muslims’ belief that religion prohibits non-caring actions that are harmful to health such as eating in excess, smoking cigarettes or water pipes, consuming pork products (including gelatin), drinking alcohol or blood, taking illicit drugs, homosexuality, and engaging in sexual activities outside of the marriage bond; therefore abstaining from all of the above prevents illness. Additional non-caring actions according to Syrian Muslims include going to bed late, shaking hands, hugging, kissing, and intermingling in intimate ways with members of
the opposite sex: “When you stay up and go to bed late, you ruin your health, the prophet, peace be upon him, told us that we should eat in moderation, go to bed early, and wake up early, this is good for our health” (K06). Applying Islamic teachings yields protective care effects such as preventing sexually transmitted diseases, drug addictions, and alcohol problems: “…Islam shields people from several problems that are common in other cultures such as the high divorce rate, broken families, and drug and alcohol abuse, of course, this does not mean that other cultures are bad. Many young Syrians are now smoking Argeeleh (water pipe), they think it’s cool, they don’t understand how harmful it is. If they followed their religion, they would not smoke and they would be healthier” (G20).

The pattern of engaging in caring actions according to Islam to promote physical and psychological health was supported by the belief that Islam fosters care actions that positively influence physical and psychological health. Syrian Muslims believe that the teachings of Islam and having faith in them provide a sense of peace that promotes spiritual health. Generic care practices such as reading the holy book and engaging in prayer were credited for enhancing spiritual, emotional, physical, mental, and psychological health. Informants maintained that drifting away from religion is believed to be detrimental to their well-being whereas getting close to it lifts their spirits and improves emotional and psychological health: “Trusting in my religion makes me feel safe, stable, happy, and stress-free” (K10).

Health promotion is valued by Syrian Muslims who believe that they have to maintain good health in order to be able to practice and meet the requirements of their faith. The belief that Muslims should care for their bodies and health was also supported by Abdal Ati (1998) who maintained that Muslims believe that they are trustees of the gifts bestowed upon them by God and should therefore handle this trust the best they can. Caring actions that promote health according to Islam include exercising, sleeping early, waking up early, fasting, praying, eating in moderation, and following the example of the prophet. The Syrian Muslim generic care practice of cleanliness is maintained by performing ablution, brushing the teeth with a toothbrush or a small tree stick called Miswak, showering, cleaning the genitalia after using the toilet through the use of watering cans, and trimming nails.

The care practices of fasting and praying, reported by informants as benefiting health, were supported by several authors. Accordingly, fasting fine tunes the body and sheds it of obesity (Hamid, 1996). In addition, it ensures the body and the soul against all the harm which results from overburdening the stomach (Abdal Ati, 1998). Ramadan fasting was identified as the ideal care practice for the treatment of obesity, essential hypertension, and mild to moderate stable type II Diabetes as it was found to lower blood sugar and systolic blood pressure (Athar, 2005). Furthermore, in addition to the benefit of exercise, the care practice of prayer was found to help Muslims in maintaining a sense of health and well-being, intellectual meditation, spiritual devotion, and moral elevation (Abdal Ati, 1998; Luna, 1989; Wehbe-Alamah, 1999).

Illness as a caring practice from God was the third pattern identified in support of Theme Three. Syrian Muslims view illness as a sign of love from God. They believe that illnesses erase their sins in this lifetime and take away from their punishment in the afterlife: “…illness is a blessing in disguise and as a sign of mercy and loving care from God” (K03). In addition, illness is viewed by Syrian Muslims as a physiologic and spiritual wake up call since it alerts them to the need to pay attention and provide better care to the body. It also reminds them of the need and duty to remember and worship God: “When I get sick, it’s God’s way of telling me wake
up! I have strayed away from Him, and I need to try to be closer to Him through prayer. It also means I have to be patient because God is erasing my sins when I suffer from illness, even when I get a paper cut” (K07). Illness as a care practice to erase one’s sins was similarly discovered in a study conducted with Lebanese Muslims (Wehbe-Alamah, 1999).

Syrian Muslims use their language as a religious protective caring practice. Syrian Muslim informants revealed that they use Arabic religious expressions such as Inshaallah (God willing), MashaAllah (what God wills) and Subhanallah (Glory be to God) to praise God and His prophets, protect people from the evil eye, and preserve or bless material possessions. All informants stated that language is used by Syrian Muslims to recite specific chapters from the Qur'an known as Al-Muawwathat or The Exorcists, which are believed to ward off and treat the evil eye: “When women go into labor or someone is having surgery, we meet and read a chapter from the Qur'an called Surat Yasseen to help the woman in labor and to protect the person having surgery” (G16). Reading Surat Al-Baqarah every three days is believed to prevent the devil from entering the house and causing trouble among the husband and wife. In addition, Syrian Muslims use language to recite supplications to God known as Dua', before performing simple daily activities such as eating, sleeping, and making love to their spouses, in an effort to protect themselves from harm: “When I married my husband and before we made love for the first time, we said a special prayer so God would bless our union and so we would have a blessed child if I was to get pregnant” (K04). Language as protective care was also discovered in another Middle Eastern Arab culture. Lebanese Muslims were also found to consider language as protective care in two other studies (Luna, 1989; Wehbe-Alamah, 1999).

Theme Three was also supported in the literature. The belief that God’s prescriptions were in the best interest of mankind and His prohibitions were aimed to protect it was found to be a common belief shared by the majority of Muslims (Abdal Ati, 1998). A review of the literature revealed that religious people tended to have healthier lifestyles and fewer physical and mental disorders. In addition, religion was seen to have a direct preventive health effect by promoting the avoidance of unhealthy habits and the promotion of a strong social support network (Koenig, 1999).

**Modes of Decision-making and Syrian Muslim Culture Care**

In accordance with Leininger’s Culture Care Theory (1991), this study discovered culture care meanings, beliefs, and practices of Syrian Muslims in urban communities in the Midwestern US. Leininger proposed that the discovery of universalities and diversities in human care in a specific culture enables nurses to plan and provide culturally congruent care for members belonging to that culture. The discovery of culture care meanings, beliefs, and practices of Syrian Muslims could enable nurses to make care decisions and initiate care actions that are culturally congruent for members belonging to that culture. The discovery of culture care meanings, beliefs, and practices of Syrian Muslims could enable nurses to make care decisions and initiate care actions that are culturally congruent with the lifeways of Syrian Muslims living in the Midwestern US and possibly with other traditional Arab Muslims as well. Such care decisions and actions, with consideration of the qualitative criterion of transferability and guided by the three modes of care in the Culture Care Theory may have similar meanings in other contexts with Muslim patients for the criterion of transferability to be met.

**Culture Care Preservation and/or Maintenance**

In order to preserve or maintain the culture care of the Syrian/Arab Muslim patients, nurses and other health care providers are encouraged to abstain from initiating shaking hands with patients of the opposite
gender, and to assign same sex healthcare providers whenever possible, especially for female patients in radiology, operating and recovery rooms, and obstetrics. Most (not all) Syrian and other Arab Muslims only shake hands with, hug, or kiss people from the same sex and believe this practice to be congruent with their religion. Congruent with the findings of this study, Connelly et al. (1999) maintained that handshakes between non-related men and women were against Islamic norms, and that same-sex care providers should generally be made available to Arab Muslim patients with the exception of life-threatening circumstances.

Hospitals are encouraged to provide alcohol-free and pork-free meals and medications to Syrian Muslim and other Muslim patients. Foods containing lard or gelatin such as Jell-O, pork based insulin, elixirs and mouthwashes containing alcohol, gelatin encapsulated medications, and vitamins and drugs that contain gelatin as an ingredient are not acceptable to the majority of Muslim patients. Reading the contents of medicine and the food labels in order to rule out the presence of gelatin and/or alcohol can preserve this cultural and religious belief and practice. Connelly et al. (1999) maintains that lard, gelatin (unless specified as beef gelatin), and some forms of non-soy lecithin are pork products that are generally widespread in processed foods, and prominent in prepared foods, which justifies the wariness felt by Arab Muslim patients towards hospital meals. Finally, nurses are encouraged to avoid pressuring relatives of a deceased Muslim patient to give consent for autopsy or organ donation since Syrian Muslims consider their bodies to be a gift from God and deem themselves to be the trustees of this gift.

Culture Care Accommodation and/or Negotiation

In order to accommodate for or negotiate culture care with Syrian/Arab Muslims, nurses and other health care providers are encouraged to accommodate or negotiate the number of visitors in an inpatient setting as well as the duration of the hospital visit. The presence of a supportive network of family members and friends is extremely important for Syrian Muslims, especially since this is considered a sign of caring, as well as a social, religious, and cultural obligation and expectation. The literature supports the finding that it is common for Muslim community members who are not related to the patient to visit the sick. Health care professionals should understand that the extensive social support received by the hospitalized Arab patient is an important part of recovery, and does not impede recovery (Connelly et al., 1999).

Other ways of providing culture care accommodation for Syrian Arab Muslim patients include requesting hospitals to provide Halal (lawful) or seafood meals or allowing patients to bring homemade foods to the hospital. Nurses can also negotiate with hospital officials to provide Muslim patients with culturally congruent hospital gowns that reach all the way down to the ankles and cover the arms in order to accommodate the modesty needs of Muslim patients. Finally, nurses working in labor and delivery, surgery, and radiology are encouraged to accommodate their patients by covering their body and exposing only the body parts needed for the required procedures.

Culture Care Repatterning and/or Restructuring

In order to repattern or restructure some of the potentially harmful health practices of Syrian Muslims, nurses are encouraged to educate clients about the harmful effects of medication sharing and of taking medications without receiving proper diagnosis by a primary health care provider. Similarly, nurses can encourage clients to consult with a primary care provider such as a physi-
cian, a nurse practitioner, or a physician assistant before consumption of any lay or self-prescribed medications. In addition, nurses are encouraged to educate new Syrian Muslim immigrants who smoke cigarettes or the water pipe about the health dangers associated with smoking, as well as the effect of second hand smoke inhalation (passive smoking) on non-smokers in order to promote smoking cessation. Finally, nurses should explain the potential danger from relying solely on a social network for health care delivery and provide Syrian Muslim clients with information about appropriate resources that can assist them in purchasing or locating affordable health care.

Implications for the Discipline and Practice of Nursing

Findings from this study will contribute to the discipline of nursing and to Leininger’s theory by adding to the evolving body of transcultural nursing care knowledge related to the care of Syrian Muslims. These discoveries will expand the awareness of the importance of generic and professional care in the promotion of health and well-being of Syrian Muslims in the US. Findings from this study may be used by US health care providers such as registered nurses, nurse practitioners, and others to provide Syrian Muslims with culturally congruent and holistic care using Leininger’s three care modes within hospital and community contexts. Syrian Muslim patients are diverse in their generic care beliefs and practices. Nurses and professional health care providers cannot assume that all Syrian Muslim patients share the traditional generic care beliefs and practices discovered in this study. A cultural assessment of a patient is crucial to discovering cultural beliefs and practices and providing culturally congruent care that is tailored to the individual client. The knowledge gained from this study may be incorporated into nursing curricula when addressing culture specific care practices and may lay the foundation for future research with other cultural groups.

REFERENCES


