REVIEW ARTICLE

Supporting Muslim Patients During Advanced Illness

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ABSTRACT

Religion is an important part of many patients' cultural perspectives and value systems that influence them during advanced illness and toward the end of life when they directly face mortality. Worldwide violence perpetrated by people identifying as Muslim has been a growing fear for people living in the US and elsewhere. This fear has further increased by the tense rhetoric heard from the recent US presidential campaign and the new presidential administration. For many, this includes fear of all Muslims, the second-largest religious group in the world with 1.6 billion adherents and approximately 3.5 million in the US alone. Patient-centered care requires health professionals to look past news headlines and unchecked social media so they can deliver high-quality care to all patients. This article explores areas of importance in the context of advanced illness for practitioners of Islam. These include the conditions needed for prayer, the roles of medical treatment and religious authority, the importance of modesty, the religious concordance of clinicians, the role of family in medical decision making, advance care planning, and pain and symptom management. Initial recommendations to optimize care for Muslim patients and their families, informed by the described tenets of Muslim faith, are provided for clinicians and health systems administrators. These include Islamic cultural awareness training for staff, assessment of patients and families to determine needs, health education and decision-making outreach, and community health partnerships with local Islamic institutions.

INTRODUCTION

Adherents to the Muslim faith are a vulnerable group in health care today, subject to potential discrimination because of the widespread negative public view of Muslims. Clinicians and administrators alike, particularly in the US, can benefit from enhanced knowledge about the Muslim faith. The US has its roots in supporting the freedom of religious practice as stated in the First Amendment of the US Constitution.[1] However, worldwide violence perpetrated by people identifying as Muslims has been a growing concern for US citizens. This tension has been further exacerbated by the rhetoric heard during the 2016 US presidential campaign and from the new presidential administration. Since the World Trade Center attacks of 2001, concerns have evolved into a generalized fear of an entire religious group practicing Islam. Clinicians and systems are not insulated from the undercurrent of discrimination against Muslims.

Islam is the world's second-largest religion with 1.6 billion practitioners worldwide and approximately 3.5 million in the US.[2] Supported by provisions of the 2010 US Affordable Care Act,[3] clinicians and hospital systems are evolving to deliver care that is more patient-centered and equitable. Projections indicate a doubling of the US Muslim population by 2030.[2] A growing and aging Muslim population will have care needs related to chronic and terminal illnesses.

Discrimination in Health Care Settings

Muslims have reported discrimination in health care settings, including denial of services, on the basis of their religion.[4-6] An *Economist* poll of 1000 adult US citizens found that Muslims face "a great deal" (39%) of discrimination in America.[7] Respondents reportedly perceived discrimination to be higher for Muslims than for Christians (23% reporting "a great deal" and 16% reporting "a fair amount" of discrimination) or for Jews (33% and 11%, respectively).[7] Muslims are also more likely to report depression as a result of discriminatory verbal insults compared with those not subjected to such treatment.[8] The Institute of Medicine described racial and ethnic disparities in health care as arising from broader historic and contemporary social inequality, influencing clinician bias and prejudice.[9] Patient-centered care requires us to look past news headlines and unchecked social media to deliver high-quality care to patients. In the setting of chronic, serious, or terminal illness, Muslim patients—like any ill patient—require care that meets them where they are, supporting medical as well as psychosocial needs.

Religion is an important part of many patients' cultural perspectives and value systems that come to the forefront during advanced illness and near the end of life when mortality must be addressed. Yet, religious needs are minimally met, if at all, in contemporary US health care.[10,11] Evidence suggests that health care professionals' willingness to explore patients' spiritual needs during advanced illness is low,[12] and this may stem from a lack of spiritual care knowledge and training.[13] Ignorance about Muslim culture in this regard has negative implications for shared decision making,[14] psychosocial support,[15] and management of disease.[16] One pilot intervention involving a one-hour educational intervention delivered by a Muslin chaplain demonstrated improved knowledge of Islamic teachings regarding end-of-life care among participating palliative care clinicians.[17] Additionally, the available research may reflect presumptions that being Muslim means rejecting biomedical innovation and health education when the opposite may be true.[18] Assessing and attending to religious and spiritual needs of patients with

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advanced and terminal illness is supported by the National Consensus Project[19] and the Institute of Medicine[20] in the US, and by the World Health Organization.[21]

We address areas of importance in the context of advanced illness for Muslim patients. These areas include prayer, medical treatment values, role of religious authority, modesty, medical decision making, advance care planning, and pain management. Recommendations to optimize care for Muslim patients and their families include Islamic cultural awareness training for health care staff, assessment of patients and families to determine needs, and community health partnerships with local Islamic institutions. This review is provided to familiarize the reader with tensions at the intersection of Islam and Westernized health care in advanced illness contexts. There is, of course, variation between individual Muslim patients and families. Clinicians and administrators can acknowledge and assess this variation by engaging with their patients, and asking them about their religious and spiritual needs.

Considerations for Muslim Patients and Families

The Sidebar: Case Vignette illustrates the case of a female Muslim patient with advanced illness who encounters challenges in adhering to her faith and practice during an acute care hospitalization. Real-life patient concerns and responses listed support a collaborative approach in caring for a Muslim patient.

DISCUSSION

The Sidebar: Recommendations for Culturally Sensitive Care to Muslim Patients with Advanced Illness details seven areas in which clinicians can address Muslim patients' spiritual and religious needs.

Prayer

Prayer and one's preparation for prayer play a central role in Muslim religious practice as one of the five pillars of Islam. The five pillars are profession of faith, prayer while facing toward the holy city of Mecca (in Saudi Arabia), fasting during the holy month of Ramadan, giving of alms (or *zakat*) to the poor, and pilgrimage to Mecca at least once during one's lifetime.[22] Notably, each pillar is strongly connected to prayer and devotion, a source of strength important to recovery from illness.[23] Maintaining personal cleanliness and a clean space to pray in health care settings in the midst of illness are particular challenges. This is an important concern for Muslim patients with advanced illness who spend a good deal of time in hospitals, clinics, and other health care environments.

Muslims will generally wash their hands, face, and feet in preparation for prayer (known as *wudu*).[22] *Tayammum*, touching both hands to clean sand and sweeping them over the face and hands, can be done if the person is too ill for the standard wudu ritual washing.[24] The availability of certain items, such as prayer rugs, and an acknowledgment and understanding of the importance of prayer, have been identified by some

Case Vignette

A 44-year-old Muslim woman is admitted for management of complications related to lung cancer with metastasis to her spine. She lives an independent life and is considered a financial supporter for her family. In her current state, she is becoming dependent on others, losing independence in simple activities, and is concerned about the well-being of her children. Her husband provides minimal emotional support.

During an initial visit from her Muslim chaplain she is still independent but becoming incontinent. This is affecting her ability to stay clean and pray in the traditional way. She has concerns about her children and their financial situation after her death. After a week, her condition deteriorates. She loses 60% to 70% of her independence and is now mostly confined to her bed.

The patient has increasing pain, and there is potential for palliative surgery, although surgeons are reluctant to operate given the advanced stage of illness. One surgeon agrees to operate and, while in the initial preparation stage, discovers that the woman might have tuberculosis. She is placed in an isolation room waiting for results of confirmatory studies. Her older brother visiting from abroad needs to return to his work, and she has only her husband and two young children for support.

- ***Patient's concern:*** Inability to offer her daily prayers because of frequent incontinence. ***Response:*** A Muslim chaplain informs her about using the option of *Tayammum* (dry ablution in place of ritual washing) and offering her prayers as soon as she cleans herself and changes clothes with assistance from hospital staff.
- ***Patient's concern:*** Pain control, inability to get *halal* (prepared per Islamic law specifications) meals, and not getting enough nutritious food to regain strength. ***Response:*** With staff input, the imam (an Islamic leader) counsels her on the benefit of pain control to relieve suffering under the circumstances. She is advised by the imam to start consuming all types of fruits and vegetables as well as nutritious drinks and fish from the hospital menu.
- ***Patient's concern:*** That her surgical case is being delayed because of her faith. ***Response:*** Hospital staff along with the Muslim chaplain are able to comfort her and explain the factors related to the delay.
- ***Patient's concern:*** If paralyzed after surgery, her hygiene will not be properly cared for. ***Response:*** The imam reminds her to have faith in Allah and have hope because she is in a competent medical facility. The imam reminds her that by Allah's will all her postsurgical care, including her hygiene requirements, will be taken care of by hospital staff and her family members. The treating clinician and nurse indicate their support. The imam prays with her and comforts her by indicating that special healing prayers will take place during *Jummah* (Friday noon prayer) by the hospital's Muslim community.
- ***Patient's concern:*** Support from her available family member, her husband. ***Response:*** The imam, with a hospital social worker, helps to link her husband to the Muslim community and social work supports so that he can be more resilient and supportive.

Muslims as ways to assist adherence to religious practice while ill in health care facilities.[25,26] Turning immobile Muslim patients' beds toward Mecca for prayer, making Qur'ans readily available, and replacing wall-hanging crucifixes (in traditionally Catholic hospitals) with crescents (a symbol of Islam for some adherents), if the institution will allow, have also been described as ways to make clinical space more welcoming for prayer and Islamic faith.[27]

Medical Treatment

Science, medicine, and faith are not separate in Islam. Indeed, a legacy of scientific and medical advancement is owed to the Islamic world.[28] Although the Arab Muslim influence on modern medicine is not often highlighted, Muslim faith generally welcomes innovations in health care.[5] Muslims are expected to seek treatments for curable disease and to view incurable disease as God's will.[6] Some Muslims may not wish to consider the withdrawing of care or organ donation from their loved ones.[29] However, withdrawal of futile life support in the context of inevitable death is permissible, provided it is done with informed consent.[30] Islamic law allows patients to refuse futile treatment, but it also forbids passively or actively causing death to self or others.[31] In the setting of incurable disease or terminal illness, Muslims' views may vary depending on religious and social contexts. It is advised to ascertain the views of patients and families/surrogates and to seek out Muslim clerics, imams (a mosque's prayer leader), or chaplains when possible for clarification and help with family communication.[32]

Role of Religious Authority

It can be a challenge for religious Muslims to navigate the decidedly secular US health system and the approaches to care that characterize it. Muslims may wish to consult their imam or other knowledgeable Islamic practitioner for guidance in medical decision making.[32] Although this person may not have any particular medical knowledge, this practitioner is called on to help with health care decisions, especially in the setting of severe illness.[32,33] There is evidence that patient and family requests for religious guidance increased after the 9/11 attacks in New York City because of increased stress from discrimination.[5,34] Muslim chaplains, when available, can help patients reconcile faithful practice and health care decisions in advanced illness.[27] Additionally, and importantly, *fatwas*, or authoritative religious rulings by Islamic jurists, provide guidance for Islamic adherents regarding treatment or other health decisions.[5,35] Spiritual assessment plays a critical role in determining patients' and families' needs during advanced illness,[36] but knowledge of Muslim religious authorities' power is also critical to a broader understanding of how decisions are made.

Modesty

Modesty for women in Muslim practice transcends that of members of the opposite sex. Physical modesty for women, usually involving the physical covering of the body, signifies respect for self and devotion to and respect for Allah—one of the five pillars of Islam.[22] Modesty in dress applies to men as well, but Muslim women are more iconic for their modest attire.[37] Modesty in one's affairs—language and actions—applies to both men and women and shows respect for society, interpersonal relationships, and Allah.[38] This includes refraining from vanity as well as unlawful or hurtful behavior. Although some non-Muslims may view aspects of this requirement to be extreme, such as Muslim women's wearing of the *hijab* (head/body cover variations), knowledge of its purpose is important in understanding Islam and, ultimately, providing culturally sensitive care. The experience of advanced or terminal illness adds another layer to this culturally and religiously embedded behavior, particularly for women. Losing the ability to be independent and care for others, requiring instead to be cared for in institutional settings, makes control of one's body and its image much more important.[39]

Gender concordance of clinicians is linked to modesty as well. A Muslim woman or man may require that the treating clinician be the same sex as themselves.[40] Honoring such a preference, a preference that may be shared by non-Muslims as well, will allow for optimal patient assessment and relief of suffering in advanced illness. Although a religious context may be discussed here, a patient's requirement or preference for gender concordance may reflect his/her culture, religion, or simply preference.

Recommendations for Culturally Sensitive Care to Muslim Patients with Advanced Illness

- **Prayer:** Make the clinical space more welcoming for prayer and Islamic faith, such as by turning immobile Muslim patients' beds toward Mecca for prayer, making Qur'ans and prayer rugs readily available, and removing any non-Islamic religious symbols.
- **Medical Treatment:** Avoid assumptions about Muslim patients' desire for medical treatment. Frankly explore the treatment options with patients and/or surrogate decision makers.
- **Role of Religious Authority:** Invite patients, if they wish, to consult their trusted religious leaders as they make decisions about their care.
- **Modesty:** Keep patients draped and provided with gowns or other materials to maintain modesty. Ask patients about their preference for same-sex clinicians and provide, if able. Otherwise, explore the patient's preference for a trusted chaperone to be present during examination or treatment.
- **Advance Care Planning:** Ask Muslim patients about their preferences for care should they become unable to make their own decisions and document these preferences in the medical record.
- **Pain Management:** Assess patients' pain adequately, describe the options available to relieve pain, and discuss the benefits and side effects of available treatments. If pain medication is desired or not, document the patient's choice in the medical record.
- **Address Mental Health Needs:** Advanced illness is associated with many emotional and mental health issues. Identify these issues and use the patient's religious faith to help address those needs. Resources are available in this regard.[1]

1. Koenig HG, Al Shohaib S. Islam and mental health [Internet]. Seattle, WA: Amazon: Create Space; 2017 [cited 2017 Mar 27]. Available from: www.amazon.com/dp/1544730330.

Health Decision Making and Advance Care Planning

The Muslim faith and the cultures in which the Muslim faith is practiced influence the way health care decisions, including advance care planning, are made. For example, Muslim families often share health decisions for individual family members, in effect rejecting the concept of autonomous decision making typically encouraged in US health care.[41,42] An imam may assist decision making as well through counsel and interpretation of Islamic teachings.[32] Additionally, patients may prefer or request that a treating clinician is also Muslim and understands the characteristics of their faith.[5] Delivering on such a request may not be possible in some settings; however, advance care planning done truly in advance of serious illness may allow time for patients to seek a suitable Muslim clinician. Whereas life, death, and suffering is determined by Allah according to the Qur'an (57.22), the Islamic Medical Association of North America, for example, encourages the use of advance care planning to prepare for future illness. Furthermore, Muslims are permitted to refuse treatment in the context of incurable diseases and to not have undesired treatments given to them.[43]

Pain Management

First, optimal communication and supportive, empathetic care is essential in assisting pain treatment.[44] Building on this necessary foundation, there are certain considerations for Muslim patients. Although a Muslim patient may very well desire pain management and although Islamic teachings view relief of suffering as virtuous,[45] some Muslim patients may view suffering as a way to atone for their past sins. Counsel from an imam can assist this process and understanding. Furthermore, drugs that make thinking or decision making more difficult are generally eschewed, but may be accepted if the medical utility is explained to patients and families.[24] Obtaining informed consent before the administration of pain medication, although not a standard process in most US hospitals, documents the choice made.[46]

CONCLUSIONS

Some programs may offer formal training on the intersection of health care and Islam, but access is limited to certain professions such as physician trainees.[47] There is no clear evidence in the literature that a formalized training on Muslim culture is available for delivery to a multidisciplinary health care professional audience. Therefore, it is up to individual organizations to develop such a module with the help of knowledgeable Muslim community leaders. Indeed, it may be more efficient if several systems or societies (eg, American Medical Association and American Nurses Association) undertook a nonproprietary joint development that could then be borrowed by others. Interprofessional training focused on care in advanced illness for older Muslim patients might include a review of the following: The Five Pillars of Islam, Procedures Related to Prayer, Principles of Pain/Symptom Management, Role of Family and Religious Leaders in Health Decisions, Islamic Definition of Death, Obligation to Preserve Life and the Exceptions, and Procedures Related to Death.[46,48] With the growing focus on interprofessional health professions education and interdisciplinary health care delivery,[49] it may be beneficial to add a Muslim clinician to the health care team in areas where there are substantial Muslim populations. Similarly, Muslim chaplains should be made available in health care facilities, working collaboratively with local imams and facility staff to respond to patients' needs.[50]

Actively determining Muslim patients' and families' needs should be a standard practice in health care institutions. Prayer needs, modesty requirements, approaches to decision making, need for a Muslim chaplain or liaison, and dietary requirements (ie, *halal* [prepared per Islamic law specifications] or vegetarian meals) are among a Muslim's concerns during a hospital stay or care during advanced illness. Directly asking and documenting these needs or obtaining answers via other screenings (eg, during registration, questionnaires on electronic tablets) will help Muslim patients of any age feel more welcome in US health care systems where secularization is usually the norm.

Community partnerships to improve the care of Muslim patients can also be encouraged. Partnering with mosques or Islamic centers or key community leaders, such as imams, can ease the tensions between the Muslim faith and Western-style health care delivery.[32,51] Acknowledgment of the US population's religious diversity can be accomplished without personal or professional compromise, if that is a concern, by putting support and referral processes in place for Muslim patients with advanced illness.[52] Resources offered by organizations such as the Islamic Medical Association of North America (https://imana.org) may be useful to hospitals or medical practices looking to improve the services delivered to their Muslim patients.

Responding to religious and spiritual diversity acknowledges the role that one's faith can play in coping with illness and making health care decisions and aligns clinician/health system practices with health care standards regarding cultural competence.[53] A critical step toward truly patient-centered care is honoring the possibility, and reality, that patients and families are often guided by faith in the context of largely secular health care. ❖

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References

1. First Amendment to the United States Constitution, Bill of Rights (Dec 15, 1791).
2. The Pew Forum on Religion & Public Life. The global religious landscape: A report on the size and distribution of the world's major religious groups as of 2010 [Internet]. Washington, DC: Pew Research Center; 2012 Dec [cited 2017 March 1]. Available from: www.pewforum.org/files/2014/01/global-religion-full.pdf.
3. The Patient Protection and Affordable Care Act of 2010. Public Law 111-148, 111th Congress, 124 Stat 119, HR 3590, enacted 2010 Mar 23.
4. Padela AI, Gunter K, Killawi A, Heisler M. Religious values and healthcare accommodations: Voices from the American Muslim community. J Gen Intern Med 2012 Jun;27(6):708-15. DOI: https://doi.org/10.1007/s11606-011-1965-5.
5. Inhorn MC, Serour GI. Islam, medicine, and Arab-Muslim refugee health in America after 9/11. Lancet 2011 Sep 3;378(9794):935-43. DOI: https://doi.org/10.1016/s0140-6736(11)61041-6.
6. Shah SM, Ayash C, Pharaon NA, Gany FM. Arab American immigrants in New York: Health care and

cancer knowledge, attitudes, and beliefs. J Immigr Minor Health 2008 Oct;10(5):429-36. DOI: https://doi.org/10.1007/s10903-007-9106-2.

7. Frankovic K. Muslim Americans widely seen as victims of discrimination [Internet]. London, United Kingdom: Economist/YouGov; 2015 Feb 20 [cited 2017 Mar 13]. Available from: https://today.yougov.com/news/2015/02/20/muslim-americans-widely-seen-victims-discriminatio/.
8. Hodge DR, Zidan T, Husain A. Depression among Muslims in the United States: Examining the role of discrimination and spirituality as risk and protective factors. Soc Work 2016 Jan;61(1):45-52. DOI: https://doi.org/10.1093/sw/swv055.
9. Smedley BD, Stith AY, Nelson AR, editors. Unequal treatment: Confronting racial and ethnic disparities in health care. Washington, DC: The National Academies Press; 2003.
10. Balboni TA, Vanderwerker LC, Block SD, et al. Religiousness and spiritual support among advanced cancer patients and associations with end-of-life treatment preferences and quality of life. J Clin Oncol 2007 Feb 10;25(5):555-60. DOI: https://doi.org/10.1200/jco.2006.07.9046.
11. Pearce MJ, Coan AD, Herndon JE 2nd, Koenig HG, Abernethy AP. Unmet spiritual care needs impact emotional and spiritual well-being in advanced cancer patients. Support Care Cancer 2012 Oct;20(10):2269-76. DOI: https://doi.org/10.1007/s00520-011-1335-1.
12. Ernecoff NC, Curlin FA, Buddadhumaruk P, White DB. Health care professionals' responses to religious or spiritual statements by surrogate decision makers during goals-of-care discussions. JAMA Intern Med 2015 Oct;175(10):1662-9. DOI: https://doi.org/10.1001/jamainternmed.2015.4124.
13. Balboni MJ, Sullivan A, Amobi A, et al. Why is spiritual care infrequent at the end of life? Spiritual care perceptions among patients, nurses, and physicians and the role of training. J Clin Oncol 2013 Feb 1;31(4):461-7. DOI: https://doi.org/10.1200/jco.2012.44.6443.
14. Irajpour A, Ghaljaei F, Alavi M. Concept of collaboration from the Islamic perspective: The view points for health providers. J Relig Health 2015 Oct;54(5):1800-9. DOI: https://doi.org/10.1007/s10943-014-9942-z.
15. Alagraa R, Abujaber A, Chandra P, Doughty J. Evaluating psychosocial support needs of female cancer patients in the State of Qatar. Qatar Med J 2015 Apr 18;2015(1):4. DOI: https://doi.org/10.5339/qmj.2015.4.
16. Ali M, Adams A, Hossain MA, Sutin D, Han BH. Primary care providers' knowledge and practices of diabetes management during Ramadan. J Prim Care Community Health 2016 Jan;7(1):33-7. DOI: https://doi.org/10.1177/2150131915601359.
17. Leong M, Olnick S, Akmal T, Copenhaver A, Razzak R. How Islam influences end-of-life care: Education for palliative care clinicians. J Pain Symptom Manage 2016 Dec;52(6):771-774.e773. DOI: https://doi.org/10.1016/j.jpainsymman.2016.05.034.
18. Laird LD, de Marrais J, Barnes LL. Portraying Islam and Muslims in MEDLINE: A content analysis. Soc Sci Med 2007 Dec;65(12):2425-39. DOI: https://doi.org/10.1016/j.socscimed.2007.07.029.
19. National Consensus Project for Quality Palliative Care.Clinical practice guidelines for palliative care, 3rd edition [Internet]. Pittsburgh, PA: National Consensus Project; 2013 [cited 2017 Mar 22]. Available from: www.nationalconsensusproject.org/NCP_Clinical_Practice_Guidelines_3rd_Edition.pdf.
20. Institute of Medicine. Dying in America: Improving quality and honoring individual preferences near the end of life. Washington, DC: The National Academies Press; 2014 Sep 17.
21. World Health Organization. WHO definition of palliative care [Internet]. Geneva, Switzerland: World Health Organization; c2017 [cited 2017 March 1]. Available from: www.who.int/cancer/palliative/definition/en/.
22. Ahmed A. Discovering Islam: Making sense of Muslim history and society. Revised ed. New York, NY: Routledge; 2002.
23. Eltaiba N, Harries M. Reflections on recovery in mental health: Perspectives from a Muslim culture. Soc Work Health Care 2015;54(8):725-37. DOI: https://doi.org/10.1080/00981389.2015.1046574.
24. al-Shahri MZ, al-Khenaizan A. Palliative care for Muslim patients. J Support Oncol 2005 Nov-Dec;3(6):432-6.
25. Davidson JE, Boyer ML, Casey D, Matzel SC, Walden CD. Gap analysis of cultural and religious needs of hospitalized patients. Crit Care Nurs Q 2008 Apr-Jun;31(2):119-26. DOI: https://doi.org/10.1097/01.cnq.0000314472.33883.d4.
26. Mir G, Sheikh A. "Fasting and prayer don't concern the doctors ... they don't even know what it is": Communication, decision-making and perceived social relations of Pakistani Muslim patients with long-term illnesses. Ethn Health 2010 Aug;15(4):327-42. DOI: https://doi.org/10.1080/13557851003624273.
27. Abu-Ras W, Laird L. How Muslim and non-Muslim chaplains serve Muslim patients? Does the interfaith chaplaincy model have room for Muslims' experiences? J Relig Health 2011 Mar;50(1):46-61. DOI: https://doi.org/10.1007/s10943-010-9357-4.
28. Majeed A. How Islam changed medicine. BMJ 2005 Dec 24;331(7531):1486-7. DOI: https://doi.org/10.1136/bmj.331.7531.1486.
29. Khalid I, Hamad WJ, Khalid TJ, Kadri M, Qushmaq I. End-of-life care in Muslim brain-dead patients: A 10-year experience. Am J Hosp Palliat Care 2013 Aug;30(5):413-8. DOI: https://doi.org/10.1177/1049909112452625.
30. Sachedina A. End-of-life: The Islamic view. Lancet 2005 Aug 27-Sep 2;366(9487):774-9. DOI: https://doi.org/10.1016/s0140-6736(05)67183-8.
31. Babgi A. Legal issues in end-of-life care: Perspectives from Saudi Arabia and United States. Am J Hosp Palliat Care 2009 Aprr-May;26(2):119-27. DOI: https://doi.org/10.1177/1049909108330031.
32. Padela AI, Killawi A, Heisler M, Demonner S, Fetters MD. The role of imams in American Muslim health: Perspectives of Muslim community leaders in Southeast Michigan. J Relig Health 2011 Jun;50(2):359-73. DOI: https://doi.org/10.1007/s10943-010-9428-6.
33. Ahmed S, Atkin K, Hewison J, Green J. The influence of faith and religion and the role of religious and community leaders in prenatal decisions for sickle cell disorders and thalassaemia major. Prenat Diagn 2006 Sep;26(9):801-9. DOI: https://doi.org/10.1002/pd.1507.
34. Ali OM, Milstein G, Marzuk PM. The imam's role in meeting the counseling needs of Muslim communities in the United States. Psychiatr Serv 2005 Feb;56(2):202-5. DOI: https://doi.org/10.1176/appi.ps.56.2.202.
35. Miller AC. Opinions on the legitimacy of brain death among Sunni and Shi'a scholars. J Relig Health 2016 Apr;55(2):394-402. DOI: https://doi.org/10.1007/s10943-015-0157-8.
36. Harrington A. The importance of spiritual assessment when caring for older adults. Aging Soc 2016 Jan;36(1):1-16. DOI: https://doi.org/10.1017/s0144686x14001007.
37. Koenig HG. Spirituality in patient care: Why, how, when, and what. 3rd ed. West Conshohocken, PA: Templeton Press; 2013.
38. Yosef AR. Health beliefs, practice, and priorities for health care of Arab Muslims in the United States. J Transcult Nurs 2008 Jul;19(3):284-91. DOI: https://doi.org/10.1177/1043659608317450.
39. Zeilani R, Seymour JE. Muslim women's narratives about bodily change and care during critical illness: A qualitative study. J Nurs Scholarsh 2012 Mar;44(1):99-107. DOI: https://doi.org/10.1111/j.1547-5069.2011.01427.x.
40. Guimond ME, Salman K. Modesty matters: Cultural sensitivity and cervical cancer prevention in Muslim women in the United States. Nurs Womens Health 2013 Jun-Jul;17(3):210-6. DOI: https://doi.org/10.1111/1751-486x.12034.
41. da Costa DE, Ghazal H, Al Khusaiby S. Do not resuscitate orders and ethical decisions in a neonatal intensive care unit in a Muslim community. Arch Dis Child Fetal Neonatal Ed 2002 Mar;86(2):F115-9. DOI: https://doi.org/10.1136/fn.86.2.f115.
42. Beaty DD. Approaches to death and dying: A cultural comparison of Turkey and the United States. Omega (Westport) 2015;70(3):301-16. DOI: https://doi.org/10.1177/0030222815568962.
43. Al-Jahdali H, Baharoon S, Al Sayyari A, Al-Ahmad G. Advance medical directives: A proposed new approach and terminology from an Islamic perspective. Med Health Care Philos 2013 May;16(2):163-9. DOI: https://doi.org/10.1007/s11019-012-9382-z.
44. Portenoy RK. Treatment of cancer pain. Lancet 2011 Jun 25;377(9784):2236-47. DOI: https://doi.org/10.1016/s0140-6736(11)60236-5.
45. Al-Jauziyah Q. Healing with the medicine of the Prophet. 2nd ed. Manderola RJ, editor. Riyadh, Saudi Arabia: Darussalam Publishers; 2003.
46. Zaidi D. On strengthening compassionate care for Muslim patients. J Pastoral Care Counsel 2015 Sep;69(3):173-6. DOI: https://doi.org/10.1177/1542305015602708.
47. The University of Chicago Program on Medicine and Religion. Initiative on Islam and medicine: Medical student internship program [Internet]. Chicago, IL: The University of Chicago; c2017 [cited 2017 March 1]. Available from: https://pmr.uchicago.edu/training/iim-internship.
48. Sarhill N, LeGrand S, Islambouli R, Davis MP, Walsh D. The terminally ill Muslim: Death and dying from the Muslim perspective. Am J Hosp Palliat Care 2001 Jul-Aug;18(4):251-5. DOI: https://doi.org/10.1177/104990910101800409.
49. Thibault GE. Reforming health professions education will require culture change and closer ties between classroom and practice. Health Aff (Millwood) 2013 Nov;32(11):1928-32. DOI: https://doi.org/10.1377/hlthaff.2013.0827.
50. Lahaj M. End of life care and the chaplain's role on the medical team. J IMA 2011 Dec;43(3):173-8. DOI: https://doi.org/10.5915/43-3-8392.
51. Zahner SJ, Corrado SM. Local health department partnerships with faith-based organizations. J Public Health Manag Pract 2004 May-Jun;10(3):258-65. DOI: https://doi.org/10.1097/00124784-200405000-00010.
52. Winslow GR, Wehtje-Winslow BJ. Ethical boundaries of spiritual care. Med J Aust 2007 May 21;186(10 Suppl):S63-6.
53. Koenig HG, Al Shohaib S. Health and well-being in Islamic societies: Background, research, and applications. Cham, Switzerland: Springer International Publishing Switzerland; 2014.