A HERMENEUTIC PHENOMENOLOGICAL INQUIRY INTO THE LIVED EXPERIENCE OF MUSLIM PATIENTS IN AUSTRALIAN HOSPITALS

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A Hermeneutic Phenomenological Inquiry into the Lived Experience of Muslim Patients

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ABSTRACT

In the past few years, many people with an Islamic background have settled in Australia. Within the health care context, this means that health care providers must modify the care provided to ensure it meets the needs of this culturally diverse population. Little nursing research has focused on understanding the perceptions and experiences of Muslim people within health care systems, particularly in Australia. This study provided an opportunity to explore, and document the experience of the hospitalisation for Islamic people and thereby advance the available information upon which important nursing care decisions that relate to this group can be more informatively made.

This study aims to explore and interpret the lived experience of thirteen Muslim patients who had been hospitalised in an Australian hospital. The hermeneutic phenomenology of Heidegger (1967/1996), the philosophical hermeneutics of Gadamer (1989), and the ideas of van Manen (1990/1996) underpin this study. The meaning and understanding of the everyday experience of Muslim patient in a non-Islamic hospital is achieved through interpretation of the participants’ stories. Data were generated using unstructured audio-taped interviews from participants. The interviews were transcribed verbatim and analysed, then interpreted using phenomenological methods.

The two themes to emerge from the participants’ experiences are: Being-thrown-into-an-un-everyday-world and living-Islam-in-the-un-everyday-world. The theme of Being-thrown-into-an-un-everyday-world arose from the sub-themes of the awareness of self and Being an outsider. The theme living-Islam-in-the-un-everyday-world was drawn from the three sub-themes of Being the same and different, hindrances to being Muslim, and adapting-to-the-un-everyday-world.

The findings of this study provide an insight into the experience of Muslims being cared for in Australian hospitals. It is hoped that this interpretation will make a significant contribution to the care of Muslim patients by having health professionals consider how this group could be cared for in a culturally sensitive manner. It is not intended as a prescription for care but draws the reader to reflect on aspects of the Muslim faith and
how this may impact on individuals experience when in hospital. The scope of this study and the dearth of available research in this area conclude that much more research needs to be undertaken.
DECLARATION

THE UNIVERSITY OF ADELAIDE

This work contains no material which has been accepted for the award of any degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text.

I give consent to this copy of my thesis, when deposited in the University Library, being available for loan and photocopying

Signed:

Dated:
ACKNOWLEDGEMENT

It has always been my goal to write a doctoral thesis, one day…! For many years it did not look favourable at all: first being the father of three teenagers, something I never regretted but also something that does not make academic life easily attainable. In addition, I had to confront personal set-back, family problems, change a country, change of lifestyle, change of language and many other things that in the end proved not to be real impediments but rather learning opportunities. But of course, this research journey would not have been possible if it were not for the support of family members and many friends. Without acknowledging those individuals who assisted me in this process, this dissertation would not be completed. Besides I have now reached a stage where I can regard the people I met my path as people who taught me something, sometimes the hard way. I would like to thank them all for giving me this opportunity.

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Adelaide, August 2007

Nooredin Mohammadi
DEDICATION

This thesis is dedicated to Muslim patients and those health professionals who care for them. In particular, I dedicate this work to the thirteen volunteered Muslim patients who shared their stories so willingly and openly with me.

And in the memory of my father-in-law and Professor Parviz Jabalameli special supporter and inspirations who gave me support and encouragement throughout my life.
CHAPTER ONE

INTRODUCTION

1.0. Introduction

This thesis reports a research study that was designed to investigate the experience of Muslims in Australian hospitals in order for nurses to better understand cultural diversity and to facilitate appropriate care for Muslim patients. As a nurse with approximately fifteen years of practice, and the majority of those years in the clinical area, I was drawn to attempt to understand the Muslims’ experience of an Australian hospital. Also as a Muslim I felt that I had a duty to investigate this phenomenon, as a matter of consciousness raising and to confirm that Muslim patients have a right to tell their stories concerning their experiences and to share these stories with others.

My starting point was that I as a nurse was interested in issues surrounding the health of Muslim people. This was explored with my supervisors, and when examining the literature on the health needs of Muslims during hospitalisation, I could see that there was a lack of studies of Muslims who had experienced hospitalisation in a non-Islamic hospital. Although I believed Muslims and non-Muslims have in common their shared perception of health and illness and health care practices, there is always the potential for differences in perceptions among people from different cultural backgrounds.
This chapter introduces and briefly outlines the Islamic philosophy and how this philosophy shapes the live of Muslims. Islam as a culture has recently begun to receive the attention it deserves in health care provision. Health professionals have sought to understand their specific health needs and concerns by using philosophical concepts. The first section of this chapter provides an overview of Islam and Islamic philosophy. The second section provides an overview of the research problem, a statement of the research question and an overview of the content of the thesis.

1.1. Background

1.1.1. Islam: An Overview

Islam is a monotheistic religion based on the surrender to God’s will who is One. Islam is a worldwide religion with approximately 1.2 billion followers. Muslims are found all over the world, of every nation, colour and race. The majority of Muslims reside in the Middle East, North Africa, East Asia and the Pacific Islands (Islamic Council of New South Wales, 2004). Muslims are expected to live in accordance with God's laws. Islam is a complete way of life, providing a framework that shapes Muslims’ lives. All aspects of their practice including prayer, fasting, charity, and pilgrimage are intended to help meet this goal (Abdullah, 1995).

This important section provides a concise introduction to the major concepts and beliefs within that tradition, from the foundation of Islam to the present day. The central objective of this section of the chapter is to provide an overview of the fundamental issues in Islamic philosophy, provide an overview of the Muslim world and attempts to give the reader a general understanding of Islam and Muslims. It also importantly provides a discussion on the Islamic perspective of health care.
1.1.2. Islam

The Arabic word of ‘Islam’ is derived from the Arabic root ‘satima’, and means to achieve peace, peace with God, peace within oneself, and peace with the creations of God through submission to God and commitment to His guidance (Behrouznia, 2001). The meaning of Islam is submission, and total adherence to the commands of God. Islam is also understood to mean total peace that comes from surrender to the will of God Almighty. Islam is a religion that the people who profess the faith would be in harmony with the universe in which they live, for everything in this universe abides by the commands of God (Montgomery, 1961; Tabatabai, 1975).

Historically, Islam is the religion founded on the Arabian Peninsula by Prophet Mohammad (570-632) in 610 CE, during the period of history Europeans call the Middle Ages. Islam expanded rapidly after the Prophet Mohammad's death. Within a few decades, the territory under Muslim rule had extended into three continents, Asia, Africa and Europe. Prophet Mohammad was of a contemplative nature, and had long disliked the decadence of his society. At the age of forty years, Prophet Mohammad received his first revelation from God through the Archangel Gabriel (Montgomery, 1961). This revelation, which continued for twenty-three years, is known as the Quran.

The Quran is the primary and principal source of every Muslim's faith and practice. To the followers of Islam, the Quran is the very word of God as it provides a complete record of the exact words revealed by God through the Angel Gabriel to the Prophet Mohammad. The Quran was memorised by Mohammad and each verse was dictated to his followers and written according to the Prophet’s instructions (Armstrong, 1993). The Quran was crosschecked during the Prophet's lifetime. In the writing of the Quran it has been organised into chapters and verses. A chapter is called a ‘sura’ that each one having a specific name and a varying number of verses with each verse is being called ‘ayah’. Not one word of its 114 chapters has been changed over the centuries (Esack, 2002). Believers of Islam say the Quran deals with all subjects that concern people as human beings, including wisdom, doctrine, worship and law; but its basic theme is the relationship between God and His creatures (Armstrong, 1993).
The followers of Islam believe their religion is the ancient version of true Judaism and Christianity but it is global and protected (Saikal, 2003). To the followers of Islam, Christianity Judaism and Islam have the same origin. This common origin explains their similarities in many beliefs and values. They also believe these similarities are not accidental, the explanation being purported to be because all three religious traditions originate from the same source, God. The word Allah in the Arabic language means God. Gabriel (2004) asserts that neither Mohammad nor Jesus and Moses came to change the basic principle of the belief in One God, brought by earlier prophets, but to confirm and renew it. The Quran says: “… say [to the Jews and Christians] we believe in the revelation which has come down to us and in that which came down to you; our God and your God is One …” (The Quran, 29:46).

The followers of Islam believe Islam is, in essence, the same message and guidance which God revealed to all his prophets. Islam was not a new religion brought by the Prophet Mohammad in the seventh century, but only the true religion of God re-expressed in its final form.

…Say: we believe in God and that which was revealed to us, and that which was revealed to Abraham, Ismael, Isaac, Jacob, and the tribes and that which given to Moses, Jesus and to the prophets from their Lord, we make no distinction between any of them, and to Him we submit… (The Quran, 3:83).

Islam is frequently misunderstood and may even seem unusual in some parts of today's world. Perhaps this is because religion no longer dominates everyday life in Western society; whereas, for followers, Islam is life (DeTar, 1996; Esack, 2002; Fares, 2003; Johnson, 2001). However not all followers share the same views on all Islamic issues, and often there is no one standard on many of the issues Muslims face in their daily life (Behrouznia, 2001) because the believers of Islam are from a variety of cultural and ethnic groups. Saeed (2003) suggests a three level model in order to understand Islam. He points out that:

…At the first level, that is, Islam’s core values, beliefs, ideas and institutions, there is broad agreement among all Muslims. This first inner level is quite small and contains only the most basic beliefs and practices upon which there is no disagreement such as the idea of the oneness of God…The second level is the interpretation of these core values to enable
putting them into practice. Broader than first level, Muslims may have minor differences of opinion at this second level. But third level is the cultural manifestation of Islam and it is here that there are substantial differences among the Muslims (Saeed, 2003, p. 64).

In fact, most followers of Islam do not distinguish themselves by claiming membership to any particular group, but prefer to call themselves simply, Muslims.

1.1.3. Muslim and Islam in the world

The people who profess the faith of Islam are called ‘Muslims’. The Arabic word ‘Muslim’ derived from the infinitive ‘silm’ (meaning peace and salvation) comes to mean one who desires and gives peace and salvation. Thus a person who believes in and consciously follows Islam is called a Muslim and the word ‘Muslim’ means one who submits and implies complete submission to the will of God.

The principle language of Islam for all Muslims is Arabic. Muslims speaking other languages often learn the Arabic script in order to be able to read the Quran. However, such readings often only involve vocalisation without comprehension. This does not mean the word Muslim is synonymous with the word ‘Arab’ and Muslim does not refer a racial population. It is important to distinguish between Muslims and Arabs. Islam originated in Arabia and as a result many of the Arabic speaking people are Muslims, however, most of the Muslims in the world are not Arabs. Only 18% of Muslims live in the Arab world. There are Asian, European, African, Australian, American and Middle Eastern Muslims, just like there are Australian, American, Italian, Polish or African born Catholics. Similarly, there are Muslims of all skin colour and race.

Over a billion people from all races, nationalities and cultures in the world are Muslim. One person in every four humans in the world is a Muslim (Saeed, 2003). There are between six to eight million Muslims in North America, over thirty million Muslims in Western Europe and fifty to sixty million live in different parts of the Republics that were once a part of Soviet Union (Kazakhstan, Turkmenistan, Tajikistan, Kyrgyzstan, Albania and others). A significant numbers of Muslim minorities live in the South East Asia (such as China, The Philippines, Thailand, Vietnam, Burma, Sri Lanka) and in
Eastern Europe (Poland, Bulgaria, Hungary, Romania, Czechoslovakia, Yugoslavia, Bosnia-Herzegovina). Islam prevails in countries like Egypt, Syria, Jordan, Iraq, Iran, Saudi Arabia, Pakistan, Bangladesh, Turkey, Tunisia, Morocco, Algeria, Indonesia, Malaysia, Sudan, and Lebanon. The map displayed in Figure 1-1, demonstrates the distribution of the Muslims community throughout the world in 2002 (see Figure 1-1).

Figure 1-1: Population of Muslims around the world, 2002

From Global Mapping International, 2005

Muslim people are associated with two major sub-groups within this religion, Sunni and Shia. This spilt occurred in the decades immediately following the death of the Prophet in 632 AD (Tabatabai, 1975). The word ‘Sunni’ in Arabic comes from a word meaning one who follows the traditions of the Prophet. The word ‘Shia’ in Arabic means a group or supportive party of people. Sunni Muslims make up the majority that is 85% of Muslims all over the world (see the Figure 1-2). Significant populations of Shia Muslims can be found in Iran and Iraq, and large minority communities in Saudi Arabia, Yemen, Bahrain, Syria, and Lebanon. It is important to remember that despite all of these differences in opinion and practice, both Shia and Sunni Muslims share the fundamental articles of Islamic belief and are considered by most to be brethren in faith.
Islam is perceived and lived in many different ways by Muslims around the world. While it is relatively easy to write an introduction to Islam, it is extremely difficult to contextualise Islam within the Islamic community. Part of the problem is that Islam is not one thing, as is commonly thought (Saeed, 2003). It is true that there are specific fundamental ideas, beliefs, practices and values which are common to all Muslims, but as with other religions their practise may vary between countries. Muslims frequently disagree on interpretation and detail. Like any other religious tradition, Muslims have many theological orientations, legal schools and religio-cultural diversions.

1.1.4. Islamic beliefs and teachings

The religion of Islam provides a complete code of law and guidance. The following section of this chapter will provide a brief summary of the basic principles, the pillars of Islam, and some other concepts practiced within Islam. It is important to note that practically all of the terminology used in Islam is Arabic, as in the Quran. For the purpose of ensuring a clear understanding, each term is listed both in Arabic and English.
There are fundamental principles of faith which form the basis for a Muslim's belief, practice and understanding of Islam. The principles are:

- Acknowledgment of the Oneness of God (Tauheed) is the most important principle of Islam, being the cornerstone of the faith. The most emphasised aspect of God in Islam is His Unity;
- Islam requires belief in angels. They are spiritual beings created by God to obey Him and carry out His commandments. They control the forces of nature by God's command. Four of the most well known angels are: Gabriel (Jibraeel), Michael (Mikaeel), Raphael (Israfeel) and Israel (Israel) (Jackson and Peters, 2003);
- Muslims believe that God revealed His laws in stages to mankind through His prophets, and therefore accept the Torah of Moses, the Psalms of David and the Gospel of Jesus as holy books, as well as the sacred scriptures of all other messengers of God. However, Muslims believe that all such revelations were limited to a specific time and people and are not preserved in their original purity, but subject to distortions. The Quran says: “This day have I perfected for you your religion and completed My favour on you and chosen for you Islam as a religion” (The Quran 5:30);
- All of God’s prophets are believed in and revered by Muslims. Muslims are directed to make no distinction among these, and to accept them all. However, Muslims believe that the prophet Mohammad is the greatest of all the prophets, having been sent not to just one nation but to all nations and thus to all mankind;
- One of the most emphasised beliefs in the Quran is the belief in the Day of Judgement. Islam teaches that physical death is not the end of man's existence, rather it is the door to a higher form of life which can bring one closer to God, depending on one's deeds in this life;
- Muslims believe that Divine Decree controls the eventual outcome of all actions in this universe. It is the law or measure of a thing with regard to its growth and development. In the Quran the term is explained as a universal law of God which is working through the whole of creation,
extending throughout the universe. Within the boundaries of Divine Decree, man is given free will.

Muslims have five basic duties, ‘the Five Pillars of Islam’. The five pillars of Islam are the foundation of Muslim life (Lippman, 1996) and represent the principle acts of worship which are required to practice the faith. Observance and practice of these acts are obligatory for all Muslims. They are: the declaration of faith (Shahadah), five prescribed daily prayers (Salah), fasting during the month of Ramadan (Sawm), tax on wealth (Zakah), and a pilgrimage to Mecca (Hajj) and are outlined below.

The first and foremost pillar of Islam is faith or belief in the Oneness of God and the finality of the prophethood of Mohammad. The declaration of faith is called the Shahadah, a simple formula that all the faithful pronounce. The significance of this declaration is the belief that the only purpose of life is to serve and obey God, and this is achieved through the teachings and practices of the last prophet.

The next Islamic pillar is the establishment of the daily prayers. Salah is the name for the obligatory prayers that are performed five times a day. The five daily prayers are:

- Fajr: This prayer should be offered in the morning about one hour before sunrise.
- Zuhr: The time for this prayer is early afternoon, starting with the decline of the sun to mid afternoon.
- Asr: Prayer is said in late afternoon but no later than half an hour before sunset.
- Maghrib: This prayer should be observed shortly after sunset. It must not be said while the sun is setting.
- Isha: This prayer should be offered after nightfall when it is dark. It can be said up to midnight.

These prayers should be performed at their appropriate times and preferably in congregation. Prayers are led by a learned person who knows the Quran and is generally chosen by the congregation. In addition to salah that is compulsory for believers, Muslims may offer voluntary prayers. Prayers contain verses from the Quran, and are said in Arabic, the language of the Revelation. However Muslims believe that personal
supplications can be offered in one's own language and at any time. Although it is preferable to worship together in a mosque, a Muslim may pray almost anywhere, such as in fields, offices, factories and universities. During prayer Muslims must face in the direction of the Kabah, the central place of worship. Abraham and his eldest son, Ishmael, were commanded by God to build a place of worship, the Kabah, in what is today the city of Mecca, Saudi Arabia. The Kabah is a simple stone construction erected as a sanctuary for the worship of the One God. Islam also provides prayers for every need and occasion. Another form of prayer is remembrance of God throughout the day (Zikre-illahi). In addition, a Muslim may pray silently to God at any time. This is known as Dua.

Fasting is the next pillar of Islam. Muslims believe that fasting is mainly a method of self-purification and self-restraint. All able adult Muslims fast from sunrise until sundown in order to get self-purification in the month of Ramadan. The Quran allows exemption from fasting to the elderly, the chronically sick and children. Temporary exemption is permitted to those travelling, the sick, pregnant and nursing women and menstruating women. They are expected to make up the fasts at a later time if they are healthy and able. Children begin to fast and to observe prayers, from puberty, although many start earlier.

Tax on wealth, Zakah, is the fourth Islamic pillar. The word Zakah means both purification and growth. It is an important principle of Islam and is that everything belongs to God. Each Muslim calculates his or her own Zakah individually. This involves the annual payment of a fortieth of one's capital, excluding such items as primary residence, car and professional tools. An individual may also give as much as they please (known as Sadaqah) but does so preferably in secret. Although this word can be translated as voluntary charity, it has a wider meaning.

The last Islamic pillar is the pilgrimage to Mecca for those who are able. The pilgrimage to Mecca, the Hajj, is an obligation only for those who are physically and financially able to do so. Nevertheless, over two million people go to Mecca each year from every corner of the globe providing a unique opportunity for those of different nations to meet one another. The annual Hajj begins in the twelfth month of the Islamic year, which is
lunar, not solar. Therefore, Hajj and Ramadan fall sometimes in summer, sometimes in winter.

Fiqah or Sharia refers to the religious laws which guide Muslims in the practical living of their daily lives. There are three sources of Islamic law: the Quran, the Sunnah and the Hadith.

For Muslims, the Quran is the Holy Word of God conveyed to the prophet Mohammad by Divine revelation. It contains a complete code of teachings and laws suitable to the needs of every age and provides the means for the spiritual and moral development of all mankind, as well as providing the remedy for its ills. The Quran explains the true purpose for man's existence, which is to worship and serve God, his Creator, and to attain nearness to Him. God has created human beings with the faculties that are appropriate for this aim, and revealed the Quran so that he may seek God through it (Motahari, 2000).

Muslims believe that practice of the prophet Mohammad (Sunnah) is the transformation of the laws and teachings of the Quran into action. By demonstrating the Word of God in a practical way, the prophet Mohammad simplified the problems of day to day living. Sayings of the prophet Mohammad (Hadith) means the words actually spoken by the prophet, or words that describe an observed incident related to his life. Hadith encompass every aspect of Islamic teachings and philosophy.

This section has attempted to give you a brief outline of a Muslim's basic beliefs and principles that Muslims share. Although substantial diversity exists among Muslims around the world, 1300 million of them, agree in the belief in one God, the prophethood of Mohammad, life after death, and basic practices such as five daily prayers, fasting, giving charity and pilgrimage. However they differ with one another on the interpretation and understanding of some Islamic beliefs and their practice.
1.1.5. Muslim population in Australia

The exact date when the first Muslim arrived in Australia has not been ascertained. Some records indicate that Muslim contact with the Australian continent predates the arrival of the first European immigrants. It has been stated that the fishermen of Makassar (now Indonesia a place where large number of Muslims reside) had been visiting northern coasts of Australia in the 16th century (Gunawan, 1988; Rauf, 2005). However most historians agree that the first major permanent settlement of Muslims in Australia came in the 1870s with the arrival of Dost Mohammad, the Afghan camel handler who developed the camel transport industry, which opened up much of central Australia (Rauf, 2005).

Thereafter with the introduction of the White Australia policy, Muslims made up only a very small fraction of immigrants to Australia so that at the 1947 Census, only 0.04 per cent, 2704 person, of the Australian population reported being Muslim (Behrouznia, 2001). Between 1911 and 1961 the number of Muslim immigrants remained constant, with a steady rise in the number of Islamic peoples immigrating to Australia since 1966. The second major wave of Muslims immigrated to Australia in the 1980s and 1990s, most coming from South and South East Asia to Australia, especially from Indonesia and Malaysia (Australian Bureau of Statistics, 1986).

Figure 1-3: Australian Muslim population by state and territory, 2001

NOTE: This figure is included on page 12 of the print copy of the thesis held in the University of Adelaide Library.

From Human Rights and Equal Opportunity Commission, 2005
As can be seen in Figure 1-3, the greatest proportion of the Muslim population resided in Sydney and Melbourne in 2001 (Rauf, 2005). According to the 2006 Census, the Australian Bureau of Statistics reported that the number of Muslims residing in Australia was 340,392 persons, approximately 1.7% of the total population, of whom approximately 52.2% were male and 47.8% were female. As can be seen in Figure 1-3, the greatest proportion of the Muslim population resided in Sydney and Melbourne at that time (Australian Bureau of Statistics, 2006).

The proportional distribution of Muslims in 2001 within states and territories of Australia are outlined in Table 1-1 below. According to the 2006 Census, the proportion of Muslims population in South Australia where the research was conducted was only 3.1% of Australian Muslims. In addition, the proportion of South Australian residents who were Muslim within this state was only 0.7%.

Table 1-1: Geographic Distribution of Muslims in Australia, 2006

<table>
<thead>
<tr>
<th>State/Territory</th>
<th>Percentage of Total Muslim Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Australia</td>
<td>3.1%</td>
</tr>
<tr>
<td>Other States</td>
<td>96.9%</td>
</tr>
</tbody>
</table>

From Australian Bureau of Statistics, 2006

Although these numbers are relatively low, they do show that there has been a considerably increase in the Muslim population. Australian Muslims are not a homogenous group. Most of Muslims in Australia are Sunni but there is a significant minority of Shia as well (Behrouznia, 2001). Since the 2001 Census did not make distinctions between these groups, it is difficult to estimate their specific numbers. Australian Muslims bring with themselves cultural differences
from their home countries as well as various interpretations of Islam, (Behrouznia, 2001). Complicating this further is the fact that more than 36 per cent of Australian Muslims are born in this country (Australian Bureau Statistics, 2001), therefore their experience of Islam is within the Australian context.

Based on statistical information, it appears that there is a Muslim population sufficient to consider the possible challenges posed to the Australian health and nursing system in terms of cultural diversity. The focus of the next section is to provide an awareness of Islamic health practices, health behaviors, and the framework of Islamic perspectives of caring.

1.1.6. Caring from an Islamic perspective

The Islamic perspective of man has important consequences upon Muslim patients understanding of health and illness (Salleh, 1994). According to Islam, man is a creature of body, soul, and spirit. Therefore health is viewed in Islam in a holistic way (Rajaram and Rashidi, 2003) that incorporates the physical, intellectual, psychological, and spiritual aspects of health. However there is a great diversity of culture among Muslim people. Although the cultural traditions of Arabs, Turks, Persians, South Asians, Africans, Europeans, and others can affect the way in which particular Muslims respond to health and illness, there are religious obligations and practices associated with Islam that commonly affect health care practice and beliefs. The roots of the Islamic perspective on health and illness are clearly established in the Quran and Sunnah of the Prophet Mohammad. The Quran seldom speaks directly to issues of health and illness although the Quran is the primary source for a shared spiritual and religious response to sickness among Muslims.

Muslims believe in life after death and the meaning of health for Muslims is “a spiritual sense of unity and beliefs about God and God’s will inspired their reflections and beliefs about life and the meaning of health and illness” (Emami, Benner, and Ekman, 2001, p. 19). From the Islamic perspective, health and illness become part of the continuum of being a human, and prayer remains the salvation in both health and in sickness. In both health and illness states, Islam enjoins Muslims to provide a proper
treatment for their body. For Muslims, Illness is one of the forms of experience by which humans arrive at a knowledge of God (Al-Ghazzali, 1970). Muslims consider an illness as a trial from God and bear it with patience, resignation, and thankfulness. Chisti (1985) states an illness is as a mechanism of the body in order to balance the physical, psychological, intellectual and spiritual health. However, this does not mean that Muslims ought to prefer illness to health. Islam teaches Muslims to have the proper attitudes and responsibilities towards illness. Muslims seek medical treatment and care for their illness.

The Islamic notion incorporates the overall health, welfare, and well-being of the body and attention has been paid to all aspects of human needs. In Islam, the complete fulfilment of all the needs of the body is defined by the Divine law of Islam (Salleh, 1994). For Muslims, observing the Islamic religious law harmoniously fulfils their physical, psychological, and spiritual needs. Human well-being is the goal of Islam. The purpose of Islamic legislation in relation to the basic needs of humans such as food, sex, and dress, is to ensure not only physical health but also spiritual and psychological health.

Consequently, the practice of caring in Islam is based upon principles derived from the basic teaching of the religion of Islam that is permanent. For example, physical modesty is an important part of Islamic ritual life and Muslim culture. It is very important for health care providers to respect the different norms of modesty Muslim patients may have, in order to preserve their dignity. Many people, not just Muslims, feel uncomfortable waiting in a hospital hallway on a stretcher, covered only by a thin sheet. For many Muslims, however, this degree of exposure is exceedingly abnormal and embarrassing (Mattson, 2004).

It means that considerations should be given to issues of religious observance, dietary requirements, modesty in dress, and spiritual development. There is limited research that addresses the religious aspects of caring within the context of Islamic culture. Rassool (2000) explains that the concept of caring is embedded in the theological framework of Islam, and nursing models from the western tradition are devoid of the core of spirituality and religious covenant. There are no Muslim models of nursing care
in the literature and little has been written on the development of a theoretical framework of caring from an Islamic perspective.

1.2. Significance of the Study

In the past few years, many people with an Islamic background have settled in Australia. Within the health care context, this means that health care providers must modify the care provided to ensure it meets the needs of this culturally diverse population. The meeting of Muslims’ needs could assist patients from an Islamic background to better adjust to the health care environment, cope with their illness and suffering, and to be empowered to participate in their own nursing and medical care.

Although the importance of the Islamic philosophy in the provision of nursing care to Muslims is well documented, few studies have examined the needs of Muslim patients during hospitalisation in an acute health setting. With an increase number of Muslims residing within Australia over the last two decades, this is an area that warrants further attention. Moreover health care standards state that patients will have their individual needs met when receiving health care. This study was designed to explore this issue and to begin the process of identifying and articulating the need of Muslim people receiving health care within Australian society.

Although Tsianakas and Liamputtong (2002) conducted a qualitative study that examined the satisfaction of fifteen women from an Islamic background with antenatal care and prenatal services in Australia, little nursing research has focused on understanding the perceptions and experiences of Muslim people within health care systems, particularly in Australia. It is therefore possible that health professionals in Australia do not understand Islamic health care issues. Research in this area could provide valuable information for future practice. This study provided an opportunity to explore, and document the experience of hospitalisation for Islamic people and thereby advance the available information upon which important nursing care decisions that relate to this group can be more informatively made.
This study aimed to identify important information that could be used to inform nursing practices that more appropriately meets the needs of Muslim patients. The focus of the study was placed upon identifying the caring experience from an Islamic perspective. By exploring the experience of the Muslim people who participated in this study valuable information was gained which will contribute to the development of more informed nursing care delivery and inform nursing care decisions that may have direct impact on patient care in the future.

The story of Muslims who had experienced hospitalisation in an Australian hospital was central to this study. Their experiences provided a text against which nurses can evaluate their practices towards minority groups, particularly Muslim patients. Their stories are written in language that is readily accessible to all health professionals, including those outside of nursing. Recognising and respecting Muslims’ needs and experiences are key considerations in the delivery of appropriate nursing care and patient outcomes. The findings of the study will help to highlight issues that Muslims perceive to be important during hospitalisation.

1.3. Purpose of the Study

The purpose of this hermeneutic phenomenological research was: to explore the lived experience of individuals from an Islamic background as a Muslim patient in an Australian hospital; to articulate these experiences; and to formulate recommendations for further practice. This was achieved through interviews with Islamic people who have been hospitalised in an Australian hospital and interpretation of their story.
Chapter One: Introduction

1.4. Research Question

This study was guided by a series of initial questions. These questions were subsumed into the main research question that reflected the principle concern of the study. The following questions were raised during the initial phase of developing this research study: is a Western paradigm of nursing care applicable to Muslims in Australia; is the provided nursing care appropriate for Islamic people; do the needs of Muslim patients differ from other groups of patients; have Muslims any specific needs when they are admitted in an Australian hospital; do nurses identify the specific needs of Muslims; how do nurses respond to these needs. After consideration of these questions of inquiry an overall research question was formulated: What do people from an Islamic background experience in Australian hospitals during hospitalisation?

1.5. Organisation of the Study

This thesis provides a comprehensive report of the research conducted and is presented in the following eight chapters. The introduction, literature review, research methodology and research method chapters discuss the study background and design. The study findings are presented in chapter seven as part of a hermeneutic phenomenological account of Islamic peoples experience during hospitalisation in a non-Islamic hospital. The concluding chapter closes the hermeneutic phenomenology and concludes the thesis. This thesis is summarised in the following overview:

Chapter One: The introduction provides the background, purpose and justification of the research. The organisation of the study completes the chapter.

Chapter Two: The literature review presents an exploration of broad study area through the literature. Past, present and future issues that impact upon the culture of the Islamic people in hospital are explored, and the relationship between the literature and the research purpose and design is established. The sources of literature that have been searched have predominantly been within the health care setting and specifically those in the field of cultural studies.
Chapter Three: This chapter introduces hermeneutic phenomenology as the research methodology. The historical development of phenomenology and hermeneutic phenomenology is traced. This chapter consider the various methodological approaches of phenomenology and hermeneutics to determine an appropriate philosophical underpinning of this study. This chapter discusses two of the major proponents of phenomenology, Husserl and Heidegger. The chapter provides the rational for decision to follow hermeneutic phenomenology as the framework for this study and will assist the reader in following the reasons for my choice.

Chapter Four: The research method presents the research strategies used in the study. This chapter explains the guidelines developed by van Manen (1990/1997). The chapter discusses the participants, the recruitment strategies, the ethical considerations, data generation method, and data analysis process. The issue of trustworthiness and rigour of the study is discussed in this chapter.

Chapter Five: A brief overview of the participants and how initial understanding emerged from the participants’ stories.

Chapter Six: An overview of the process of finding meaning and how Gadamerian philosophy and the notions of van Manen were used to emerge the meaning of the phenomenon of being a Muslim patient in a non-Islamic hospital.

Chapter Seven: The chapter presents the interpretation, which involves the Muslims’ own stories and conversations. The chapter gives an overview of significant statements, sub-themes and themes, which emerged from data. The focus of the chapter is the exploration of how each theme is supported by the Muslims’ experiences. The themes, which emerged from data, were Being-thrown-into-an un-everyday-world and living-Islam-in-the un-everyday-world.

Chapter Eight: This final chapter is the concluding chapter of the inquiry and presents a summary of the two themes that have emerged from the inquiry. These themes are discussed. Then the limitation of this research study is discussed. The chapter considers
the study’s significance and makes recommendations for future inquiry into the care of Islamic people.

**Appendices** Contain the participants’ information sheet (English and Farsi versions), advertising flyer (English and Farsi versions), the ethics approval, and the consent form (English and Farsi versions).

### 1.6. Summary

This chapter introduced the topic of the research and how the researcher’s interest in the study manifested itself. An overview of Islam and Islamic philosophy is provided in this chapter. The chapter presents the significance of the study and the justification for the conduct of the study. The purpose of research and the research question is presented. A summary of the chapters in this thesis was also provided. The next chapter, literature review, summarises existing research literature.
CHAPTER TWO
LITERATURE REVIEW

2.0. Introduction

The purpose of this literature review is to establish what research has been done, to determine the gaps or inconsistencies in the literature, and to develop arguments for the need for this phenomenological study. Literature was sought that focused on what is known about the specific needs of people from different cultural backgrounds and the role of cultural issues in the acute care health setting. The literature review discusses the issue of culture and cultural diversity, ethnic minority groups, cultural competency, and the experience of Muslims within Western society.

An online search, which focused primarily on electronic databases of the Cumulative Index to Nursing and Allied Health Literature (CINAHL) and MEDLINE, was undertaken and limited to literature written in English. Relevant documents were recorded in a separate EndNote library. In order to undertake a review of the recent medical and scientific literature, the search was originally restricted to research published between 2001 and 2006. This time frame was determined based on an initial sweep of the literature and recommendation by experts however, the result was deemed to be too limited. For the next stage of my review, the time frame was extended back to 1991 in order to capture a greater sample of the complimentary research using specific keywords informed by initial search. In addition, the review sought to access grey
literature. ‘Grey literature’ is defined at Seventh International Conference on Grey Literature as “information produced at all levels of government, academics, business, and industry in electronic and print formats not controlled by commercial publishing i.e. where publishing is not the primary activity of the producing body” (Jeffery and Asserson, 2005, online). The mechanism of identifying relevant grey literature was supplemented by targeted searches using standard Internet search engines, particularly Google. In many cases, these searches were informed by clues gained from perusal of previously collected materials. The grey literature included reports, statistics, theses, conferences, non-research publications and the work of authorities in the field, and Islamic perspectives on the health issues.

2.1. Culture

2.1.1. Demographic change in Australia

The term ‘demographic change’ may be taken literally to refer to any change affecting a given population (Davey, 2002). Although a more traditional interpretation of the term restricts changes of interest to those affecting the size and structure of that population, demography comprises two elements: population composition and population dynamics. Population composition describes the main characteristics of a given population such as its size and distribution across an age profile. Population dynamics deals with changes over time, in absolute or relative terms, and focuses on effects from alterations to fertility, mortality, and net migration (Aars and Ims, 2000). Even under this relatively narrow definition, the range of such changes can be quite large. This is because the makeup of a group of persons can change in terms of a number of criteria, such as age, gender, ethnicity or geographical location. Each of these types of change may be associated with very diverse health flow-on effects. For instance, cultural diversity within a population can be expected to have repercussions in the area of health allocation, delivery of health services and the needs of customers. The value of demography is twofold: to identify trends in population composition over time by revealing interaction between population composition and dynamics; and to highlight crucial uncertainties in modelling assumptions (Murdock and Ellis, 1991).
Previously Australia was considered to have a primarily homogeneous population and life-style. A homogeneous population refers to people that are similar to each other or are of the same type (Birdsell, 1979). Until 1947, Australia was considered to be one of the most monolingual countries in the world (Smolicz, 1984). The 1947 census showed that only 9% of the population were born outside Australia, with only 2% from Non-English Speaking Backgrounds (NESBs). Historically, the majority of Australians came from Western backgrounds, but after World War II Australia instituted a campaign to attract immigrants from all over Europe. Since World War II immigration has accounted for 50% of Australia's population growth. In the past 50 years, more than 620,000 refugees and displaced people have been resettled in Australia from most countries around the world, including Germany, Austria, Poland, Hungary, Czechoslovakia, Greece, former Yugoslavia, Estonia, Latvia, Lithuania, Vietnam, Kampuchea, Laos, Lebanon, Chile, El Salvador, Timor, Iraq, Afghanistan, Sri Lanka, Iran, Java, Africa and China (Australian Bureau of Statistics, 2004). This level of growth, however, is often accompanied by arguments about the advantages and disadvantages of international immigration.

According to the 1986 census, 20.8% of people living in Australia were born overseas, with 11.6% being from NESBs (Australian Bureau of Statistics, 1986). The 2006 Australian Bureau of Statistic census recorded that almost 400 different languages were spoken in homes across Australia. The census also reveals that around 21% of Australia’s population spoke only English at home. The three most common languages other than English in the 2006 census were Italian (accounting for 1.6% of the population), Greek (1.3%) and Cantonese (1.2%). The recent growth of Asian languages and the decline of those Europe in Australia reflect the recent trends on birthplaces of Australia’s overseas-born. Of Australia’s main non-English languages, Mandarin and Hindi have experienced the fastest proportional growth – both more than doubling in speakers since 1996.

Australia’s overseas-born population is also increasing – up 13% from 1996. A number of Australia’s recent arrivals had been born in countries recently affected by war and political unrest. Around 14,000 of Australian residents born in Sudan had arrived in 2001 or later. Similarly, a high proportion of the population born in Zimbabwe (48%),
Afghanistan (45%), and Iraq (34%) had arrived in 2001 or later (Australian Bureau of Statistics, 2006).

Today, cultural diversity is one of the greatest strengths of Australia and this country is known as a multicultural society. Australia is a nation built by people from many different backgrounds and cultural diversity has become a touchstone of Australia's national identity. One example of this diversity is the growth of Islam in Australia. Muslims form an increasingly important part of Australia's diverse modern society and the most recent Australian Census in 2006 revealed a total of 340,392 Australian Muslims living in Australia (Australian Bureau of Statistics, 2006).

Changing demographics in both the general population and among health professionals have intensified debates about the delivery of health services in multicultural Australia. Accordingly, it might be claimed that the impact of cultural issues on health services might be more important in multicultural societies such as Australia where many ethnic minority groupings and people may have different views about health and illness. Therefore, in an era of extraordinary movement of Australian populations, it is hard to escape the impact of cultural issues on health provision. This section develops a detailed discussion of the impact of culture on health provision, exploring the needs of minority groups in this multicultural milieu, and understanding the value of cultural diversity.

### 2.1.2. Definition of culture

‘Culture’ has been defined in various ways by different scholars and for numerous purposes. There will probably never be a single definition of culture. However it is generally used to refer to beliefs, values, and behaviours. Definitions emanating from anthropology have greatly influenced definitions of culture used in nursing. Culture refers to human behaviour, social organisation, structures and ideology (Bottomley and de Lepervanche, 1990). Leininger (1983, p. 11) refers to “the learned and shared beliefs, values, and life ways of designated or particular group which are generally transmitted intergenerationally and influence one's thinking and action modes”. This definition explains a number of important concepts of culture.
Chapter Two: Literature Review

Culture, in general, refers to the language, ideas, beliefs, and behavioural norms that go with belonging to a particular social group. Therefore it makes distinction between social groups. Furthermore there is a range of norms, values, and assumptions within every culture, which creates sub-groups within each group.

Anthropologists believe that culture is as a set of learned rules, standards, or manners shared within a human group which describe a range of behaviours and beliefs that are proper, acceptable, and valid. In the other words, culture refers to how people do and view things in their group; how people should behave, how things should be organised, and what is considered right or wrong, normal or abnormal, important or unimportant.

Hampden-Turner and Trompenaars (1997) point out that these rules serve to promote the survival of the group. To Hampden-Turner and Trompenaars, everything that a group of people does is governed by rules. These rules are not necessarily written down. They are, however, handed down from generation to generation through tradition. For example, some cultural rules are: what sort of foods to eat at each meal; how many meals to have during the day; clothing styles; various religious observances; who is a friend and who is an enemy; what is artistically pleasing; marriage and sexual customs; and myths, legends, and histories. Kao, Hsu, and Clark (2004) believe that culture ultimately represents the blueprint of human living.

Culture is not inherited through biology. People learn culture from all the members of their human group, including family, peers, and neighbours. The process of learning the rules of a culture is called ‘enculturation’. Henley and Schott (2003) think that the process of enculturation is an internal one. Enculturation is an unconscious process in early childhood. Each person within a culture learns their cultural rules and decides to accept or reject those rules. Once cultural rules are in place, an individual uses those rules to govern everything they do. If a person is removed from the culture and placed into another culture, the person still follows the rules they internalised during enculturation. This produces culture shock, that feeling that a person is out of place. Because culture is learned, however, a person can begin learning the rules of a new culture.
Cultures are not spread randomly among the world’s population but are concentrated separately in different people or different ethnic groups (Sowell, 1994). While cultural rules are internalised, people within a culture share the rules and use them to interact. The members of a cultural group generally accept their culture. These rules are often invisible but they are absolutely fundamental and influence everything else. The members of a group believe that the way they live is the best way to live. Across the globe, every culture believes their own culture is the best in the world. It may become noticeable when people come into contact with another culture (Henley and Schott, 2003). Culture is true, right, and just for the people that live within that culture. Despite this, however, people within a culture can and do protest the rules.

Finally, culture is dynamic, it is not static or fixed (Allotey, Manderson, and Reidpath, 2002). Cultures change over time in response to new situations and pressures. The rules of a culture change with each generation and within a single generation. What is considered acceptable at one point in time, may become abhorrent at another point in time. Culture changes because each generation forms its own opinion about what is right and what is wrong; and culture adapts to meet environmental or social pressures, and to provide solutions for the problems members of the culture face. Cultures that can't or will not adapt to environmental pressures tend to fall apart and reshape themselves in another form.

An important point in understanding the role of culture is that it must always be seen in its particular context. This context is made up of historical, economic, social, political, and geographical elements. It means that the culture of any group of people, at any particular point in time, is always influenced by many other factors. It may, therefore, be impossible to isolate pure cultural beliefs and behaviour from the social and economic context in which they occur. For example, individuals may have high levels of anxiety in their daily lives. It is not because their culture makes them anxious, but because they may be suffering persecution from other people. Therefore, culture should never been kept separate from other elements, but it should be considered only as one component of a complex mix of influences on what people believe and how they live their lives.
2.1.3. The Impact of culture on health care

From the health care perspective, cultural issues have a crucial role in the provision of health care. Although concern about the influence of cultural issues on health care is not new, the impact of culture on health care is an issue of growing importance nationally and internationally. Cultural background has an important influence on many aspects of peoples’ lives, including our beliefs, behaviours and attitudes to illness, pain and other misfortunes, all of which may have important implications for health and health care. Culture can be central to the decision-making process for planning of health care. Murphy and Macleod (1993, p. 442) stress that “making decision about health promotion and illness prevention occur within a cultural context”.

Cultural differences have had an essential role in the long history of health care. Cultural differences among people enable health professionals to understand not only how particular people differ but also how cultural patterns in general affect the health system in societies. Nurses are expected to acknowledge and respect people and their individual cultural background, values, and their consequent needs and consider the cultural differences between groups that have influence on health care. Every culture has its own specific system of beliefs and practices (Helman, 2000) regarding health and ideas about illness.

Culture can have a direct effect on an individual’s health-related behaviours and perceptions. The impact of culture as a causative influence on the perceptions, interpretations, and behaviours of persons in specific cultural background is important. Jainism, an ancient religion and philosophy of India, is an example. Jains believe that the soul exists and it is eternal and that all living things have a soul. Thus, harming a living thing is a sin. In Jain culture, because of the prohibition against killing or harming any form of life, some Jains prefer not to take antibiotics. Most Jains will accept them but often with regret. Most people prefer to avoid drugs that contain animal or other prohibited substances, but will usually accept them if life is at risk (Cort, 1998).

The individual’s cultural context is one of the important factors that can influence a person’s perception of health and illness. For example, Jehovah’s Witnesses seek alternatives to blood transfusions because of their strong religious belief that a human
must not sustain his or her life with another creature’s blood. This is a deeply held core value. Jehovah’s Witnesses believe that if they knowingly allow transfusion of blood, they damage their personal relationship with God, and risk losing eternal life under the kingdom of God. Therefore, they are likely to refuse a blood transfusion (Holden, 2002).

Culture also influences how people seek health care and how they behave toward health care providers. How health professionals care for patients and how patients respond to this care is greatly influenced by culture. Health professionals must possess the ability and knowledge to communicate and to understand health behaviours influenced by culture. For example, culture has an effect on how people recognise and explain symptoms and show pain. Pain is a source of discomfort and the most common stimulus in making people seek medical help. There is growing appreciation that people differ biologically with thresholds to pain varying as well as physiological responses to pain medication and verbal expressions of pain. “Pain is a phenomenon with both personal and cultural meanings” (Davidhizar and Giger, 2004, p. 48).

Therefore the meaning and expression of pain are influenced by the cultural background of the person. In some cultures, pain and other symptoms are considered most important. For example, the expression of pain among Muslims has unique characteristics (Sheets and El Azhary, 1998) and is often private (Lepain, 2003). The Muslim’s worldview toward pain incorporates the notion of meditation and prayers (Rassool, 2004). For Muslims, pain is one of the forms of experience by which humans arrive at knowledge of God.

Concern by health care providers about the challenge of providing appropriate care to consumers from diverse cultures has prompted greater exploration of ways to fit care to patients’ needs. There is a parallel effort to eliminate practices and policies that require consumers of health care to adapt and conform to a limited set of norms and values in order to utilise resources (Almond, 2002). All of this points to a need to understand cultural differences among cultural groups and culturally influenced health behaviours in order to provide culturally appropriate care.
However, health professionals have to always avoid using generalisation in explaining people’s beliefs and behaviours. Generalisation can also be dangerous and often leads to the development of stereotypes, cultural misunderstandings, prejudices and also discrimination (Geldenhuys and Rossouw, 2001). Another reason why one should not generalise is that cultures are never static, but are in constant process of adaptation and change.

2.2. Minority Groups

2.2.1. Introduction to the discussion about minority groups

Australians are from a wide variety of cultural backgrounds. Therefore it is not surprising that Australia has a diverse population which can reflect in the various minority groups. As the number of Australian minority populations increase, the issue of minority groups’ health becomes a central issue in Australia. Although attention paid to the issues of minority ethnic and religious groups varies between countries on account of the size and type of minority groups in their population, there is an acknowledgement that health professionals must be prepared adequately to meet the needs of the whole population (Chevannes, 2002).

The health system in Australia is based on the principle that all Australians have a right to equitable access to health services according to need. Although Australian government is increasingly concerned with providing high-quality health services that are accessible to all, there is growing concern that the cultural healthcare needs of minority ethnic a religious groups might not met adequately (Ziguras, Stankovska, and Minas, 2003). Therefore, changes that improve provision for minority ethnic and religious patients need to consider in a standard health services for minority population to meet their different needs and circumstances as they emerge. However, a great deal has been written over the past few decades about equal access and opportunity. The issues of equal access to health care and the barriers that hinder to meet the needs of minority groups are central to current debates in relation to minority groups in the context of health care (Henley and Schott, 2003). This section provides a brief overview
of some relevant arguments of all aspects of relations between the health needs of minority groups and health systems in multicultural societies.

2.2.2. Definition of minority groups

Any discussion of minority groups brings with it the problem of definition because there is no universally accepted definition of minority groups. ‘Minority groups’ refer to those groups that are different from the majority of the population. There are a variety of minority groups in society based on political beliefs, physical disabilities, and mental health status. Minority groups can also be used to refer to people of a different language, nationality, religion, culture, life style or any characteristic. Capotorti (1991), the reporter of the United Nations Sub-Commission on Prevention of Discrimination and Protection of Minorities in 1979, proposed the following definition of a minority:

A group, numerically inferior to the rest of the population of a State, in a non-dominant position, whose members- being nationals of the State- possess ethnic, religious or linguistic characteristics differing from those of the rest of the population and show, if only implicitly, a sense of solidarity, directed towards preserving their culture, traditions, religion or language (Capotorti, 1991, p. xiv).

In Australia where English is the main language, the main language is utilised to define minority ethnic groups (Ziguras, Stankovska, and Minas, 2003). The government of the United States of America uses the definition in Webster's Dictionary for the word, minority meaning “a group differing, especially in race, religion, or ethnic background from the majority” (Merriam-Webster Online Dictionary, 2004). The concept of a minority group has sometimes been misunderstood. At times, the term ‘minority’ is used to refer to ethnicity. According to Bottomley and de Lepervanche (1990), ethnicity refers to shared origins. Also Glazer (1983, p.234) points out:

The term ethnic refers to a social group that consciously shares some aspects of a common culture and is defined primarily by descent. It is part of a family of terms of similar or related meaning, such as minority group, race, and nation, and it is not often easy to make sharp distinctions between these terms.
A ‘minority ethnic group’ refers to “a group having a common national or cultural tradition, denoting origin by birth or descent rather than nationality” (Education Guardian, 1992, p. 1). However the terms ‘minority group’ and ‘ethnicity’ are often interchangeable in the literature. Some writers use the term of ‘minority ethnic group’ in order to achieve a clear definition.

It is important to be clear about the term ‘minority religious group’ and how it is used in this study, because it sets the stage for the theoretical paradigms, research methodology and instruments used, and the interpretation process. However, measurement of religion and spirituality can be incredibly complex (Ludwig and Blank, 1969). This complexity and confusing state of categorisation would make better sense in the following example. The term ‘Muslim’ refer to one who believes in the declaration of Islamic faith, regardless of gender, race, nationality, colour, or language. Therefore, Australian Muslims can be categorised as a minority religious group they were born in Australia and speaks English language as a first language as well as they come from different ethnic backgrounds.

However, the religious label that a Muslim uses to self-identify is more important than the specific national origin, language or preferred ethnic label. The Muslim label is the shared cultural values and traditions of the Islamic population and how these shared values and traditions influence behaviour (Padilla, 1995). In this thesis, the terms of minority group, minority ethnic group and minority religious group are used interchangeably because this practice is frequently found in the literature.

Study of minority groups takes place in a context of majority-minority group relations. The subsequent section accordingly discusses the various contemporary issues about majority-minority relations in multicultural societies particularly in terms of health services.

### 2.2.3. Majority-minority relations

Sociologists define the ‘majority group’ as any group which is dominant in a society, while a ‘minority group’ is defined as any group that is assigned an inferior status
(Capotorti, 1991). Therefore the terms ‘majority’ and ‘minority’ does not indicate numbers but rather the majority is the dominant group and the minority is the subordinate group. According to Corbie-Smith (2004), the emphasis of minority group is on the relationship to the majority. The dynamic of relations between majority and minority groups are in many ways similar, regardless how those groups are formed.

Majority or minority group status is usually determined by race or ethnicity, many other factors such as sex, physical disability, lifestyle or sexual orientation can also be used to assigned group status. The stratification of people into majority and minority is not desirable whether it is based on their status in the social hierarchy.

The concept of ‘stratification’ needs to be developed in some detail. As always, the best place to start is with a definition of the concept. The Oxford English Dictionary (2005) defines the word of ‘strata’ as: "A layer, or set of successive layers, of any deposited substance; layer of atmosphere, biological tissue, or other structure". To stratify, therefore, involves the ability to, "Arrange in strata; construct in layers, social grades…" (The Oxford English Dictionary, 2005, online). It can initially suppose that if stratification involves some concept of layering which one layer being placed above or below the next, the concept of social stratification involves the idea that people, either as individuals or as groups, can be assigned to different layers or levels in the society in which they live. Thus in this respect, stratification means the various strata of society. However it is suggested that the concept of stratification must be used with care for human societies. Furthermore the social strata created by human beings in their social relationships are not fixed (Farley, 2005).

Relations between minorities and majorities in non-homogeneous societies have almost always been uneasy and often conflictual. Although sociologists frequently stratify people in the society in order to justify a system of inequality (Farley, 2005), minority-majority relationships in multicultural societies may range from open, friendly, and trusting to distrusting, hostile, or antagonistic. In addition, the relation between the majority and minority is not stable. The majority-minority relations have depended upon various factors and diverse issues like constitutional provisions, population characteristics, language, legal interpretations, and, above all, political compulsions and interpretations.
The majority-minority relationship between populations is an interesting and important factor in the provision of health care. These relationships shape patients’ experiences in the health care settings as well as their expectations for health system interventions. Majority-minority relations also influence health professionals’ perspectives on and response to minority groups’ health needs.

2.2.4. Minority groups and health care

Valuing diversity in health care enhances the delivery and effectiveness of care. The definition of minority groups not only includes race and ethnic background as qualification for minority status, but also other more controversial subgroups, such as those characterised by a distinctive alternative lifestyle. Fletcher et al. (2003) argue that just focusing on race misses the larger picture. According to Purnell (2004), the use of the term ‘minority’ is inappropriate in the context of health care because of the way it is defined and used. She states this term is simply not useful for identifying all groups that need special attention in health care delivery.

In the context of health care, minority groups, therefore, refers to groups of people who have health needs and patterns that might differ from that of the general population (Blackford, 2003; Blackford and Street, 2002; Burr, 2002; Chevannes, 2002; Chiang and Carlson, 2003). For instance, lesbian and bisexual women have specific healthcare needs in area of mental health. Gilman et al. (2001) conducted a nation study in the United States of America and found lesbian and bisexual women report rates of depression, anxiety disorders and suicidal ideation that are two to three times higher than women in the general population. There is some evidence from an Australian community sample that bisexual people have an even higher prevalence of mental health problems than lesbian and gay people (Jorm et al., 2002).

In general, minority people have shorter life expectancies and poorer physical and mental health (Andrews and Boyle, 2003; Smaje and Grand, 1997), and most often struggle with a health service which is not adequately equipped to deal with or is adequately sensitive to their needs (Bolton, Giger, and Georges, 2003; Corbie-Smith,
2004; Daker-White et al., 2002; Hussain and Cochrane, 2004). Rockville (2004) argues advances in medical science in the last century mask the fact that minority groups often fare worse than the majority on a variety of health indicators. A recent report by the Institute of Medicine, a branch of the National Academy of Sciences, found that minority groups in the United States of America tend to receive a lower quality of health care than non-minorities, even when access related factors are controlled (Smedley, Stith, and Nelson, 2003).

Undoubtedly, achieving a healthy nation is impossible without healthy minority populations and without providing appropriate health care for minority groups. Health care organisations must develop health care services in ways that meet the needs of all clients, regardless of culture or racial, ethnic, or minority status. Documents identify common barriers to access to health services for any group, including minority people. Cost, availability, service responses to the specific needs of particular groups and the availability of health care providers who speak their language all affect the extent to which minority people receive services (Purnell, 2004). These factors might lead to health inequity. Health inequities most strongly affect the most excluded and vulnerable sectors of the population (Casas-Zamora, 2002).

Any group can become a vulnerable population regardless of ethnicity or race. For example, in the early years of the acquired immunodeficiency syndrome (AIDS) crisis, all the stress on prevention and education was directed to the minority gay sub-culture, resulting in a considerable part of the population believing that other groups were not affected. However education about AIDS was directed at all vulnerable groups in the years after. Thus one can consider that an individual, family, or group from the dominant culture can fall into a vulnerable population (Purnell, 2004).

Health professionals must recognise and group people according to their specific healthcare needs. Accepting a wider view of grouping people based on health disparities could work more effectively towards eliminating barriers to effective and equitable healthcare for many ethno-cultural groups. Like other multicultural countries such as Canada, New Zealand, United Kingdom, and the United States of America, Australia have initiated or renewed its interests in multicultural diversity with a focus on decreasing minority and ethnic disparities in health (Smedley, Stith, and Nelson, 2003).
2.3. Equity of Health Services

It is unrealistic to expect health care systems to respond to every individual health needs however, they should work to reduce barriers to access experienced by vulnerable groups. Access to a conventional level of health care is part of a basic living standard that should be assured to all members of the community (Scotton and Ferber, 1978). According to health statistics, the overall health of the people around the world has improved over the past few decades, but all people have not shared equally in these improvements, “health systems are consistently inequitable” (Gwatkin, Bhuiya, and Victora, 2004, p. 1273).

Over the last decade, the issue of health disparities has become one of the most pressing problems plaguing health care systems. In fact, the problem of health disparities has lead countries to establish the ‘elimination of health disparities by 2010’ as an international goal. For example, the Ministers of Health from Chile, Germany, Greece, New Zealand, Slovenia, Sweden, and the United Kingdom established The International Forum on Common Access to Health Care Services in 2003, based on a common belief that their citizens should enjoy universal and equitable access to good quality health care (IFCAHCS, 2003).

The term ‘health disparities’ includes disparities in health and health care. Although ‘disparities in health’ and ‘disparities in health care’ are often used interchangeably, they are two different concepts. Disparities in health refer to differences between two or more population groups in health outcomes and in the prevalence, incidence, or burden of disease, disability, injury, or death (Byrne, O’Malley, and Suarez-Almazor, 2004; Fletcher et al., 2003). For instance, previous medical research has shown African-Americans are twice as likely to have diabetes than White Americans. Disparities in health care refer to the differences between two or more population groups in health care access, coverage, and quality of care, including differences in preventive,
diagnostic, and treatment services (Gomes and McGuire, 2001; Smedley, Stith, and Nelson, 2003).

The literature suggests a number of potential reasons for health care disparities. The first potential source of disparities in health care context is associated with communication difficulties. Many minority people experience difficulties in communication with their health care providers (Gerrish, 2001). Some do not speak English well and others do not speak English at all. Often they cannot find providers who speak their language. In order to explore the role of communication in delivering effective palliative care services, Randhawa et al. (2003) conducted a study in United Kingdom, and found some people minority groups believed that provided care was far from ideal. The most significant problem for these people centred on communication. Randhawa’s study has suggested that there is need to improve communication between minority populations and service providers.

The next potential source of health care disparities is provider stereotyping. A large body of research in health care has explored how stereotypes evolve, persist, shape expectations, and affect interpersonal interactions. For example, if someone says all Australians are rich, all mothers bake cookies, or people who look a certain way are dangerous, that person is using a stereotype. The beliefs, stereotypes and general orientations that people bring to their interactions help organise and simplify complex or uncertain situations and give perceivers greater confidence in their ability to understand a situation and respond in efficient and effective ways. However, some authorities argue that all stereotypes are harmful, because they judge an individual based solely on his or her being part of a particular group, regardless of his or her unique identity (Burr, 2002; Farley, 2005; Machado, 2001; Porter and E., 2004; Rice, Naksook, and Watson, 1999; Smedley, Stith, and Nelson, 2003).

Providing an equitable health service to minority groups is one of the most challenging issues in multicultural societies. What does equity in health mean? Mooney (1983) states that clarifying what equity means or should mean is a difficult but important task. Understanding the concept of equity in health services needs background information which will form the basis for understanding.
The term ‘equity’ is often confusing due to a lack of agreement on definition (Gaulton-Berks, 1998). However it is a concept that appears in a very wide range of health-related literature, such as health promotion, sociology, health economics, health and social policy, and ethics. Probably, dictionary definitions are a good starting point in order to establish greater clarity of meaning. The Longman Dictionary (1997, p. 256) definition of equity is “a situation in which everyone is fairly treated”. This is confusing because the later point alludes to equality. The Oxford English Dictionary (2005) defines equity as “being fair and impartial for example, equity of treatment”. These somewhat concise definitions do nevertheless illuminate the complexity of the concept.

The term ‘equity’ was derived from the Latin and French words, which mean equal (The Oxford English Dictionary, 2005). Although “some countries have one word, which means equity and equality” (Almond, 2002, p. 600), equity in health is not the same as equality, and at the same time, not all inequality can be seen as inequity (McClelland, 1991). Many experts agree that the concept of equity is difficult to define (Almond, 2002; Wagstaff, 2002). Wagstaff (2002) believes that equity means equality plus fairness and justice. The meaning of the concept is quite different in dictionary definitions and different disciplines.

Equity with respect to health care may be defined and interpreted in a variety of ways. Many authors agree that the concept of equity is difficult to define. Evandrou et al. (1990) define the term as equity of utilisation and equity of outcome. Bradshaw and Bradshaw (1995) argue equity means the fair distribution of services to those who need them. Gillon (1994) takes a philosophical viewpoint of equity and focuses on the ethical principle of justice. According to Schaffer and Lamb (1981, p. 2),

Equity as a concept and practice is above all a political fact. It is an ideological construct about distribution, about the apportionment of resources in society, and therefore political in the sense of an intervention in the struggle of political ideas.

In contrast to previous authors, Culyer and Wagstaff (1993) suggested that equity of health should be the dominant principle and that equity in health care should therefore entail distributing care in such a way as to get as close as is feasible to an equal distribution of health. Yet, Wagstaff (2002) refers to equity as equality of health and
equality of and distribution of health services and expenditure. Culyer and Wagstaff (1993) argue that the definitions of equity in health care; equity of utilisation, distribution according to need, equity of access, and equity of health are incompatible because of the definitions of need in the literature are inadequate. Smaje and Grand (1997) point out that with respect to any of these indices, some interpretations may require full equity of utilisation, equity of access or equity of outcome.

Therefore, there are a number of ways of considering the concept of equity in the health-related literature. It can refer to equal access for equal need, to equal distribution of resources, to equal standard or outcome, and to equal health.

Equity of access for equal need refers to all individuals in need have the same opportunity to use the same health service according to their need. Equity in relation to access to effective health care for equal need has been consistently identified as a major issue in the area of health care service. The barriers for minority population in accessing effective health services have been reported. Adamson et al. (2003) state an increasing body of evidence reveals that health services are predominantly accessed by the majority of the population.

Equity of health care resources also refers to the fair allocation of resources among different individuals, groups, and regions in society if the needs are equal. However the issue of resource allocation is complex and brings a great debate into the health system. This implies that the health care system must deal with two individuals with the same need in the same way. When considering an equitable distribution of resources in the health service, it is clear that there are specific means of assessing the situation and the problem of prioritising between conditions and between services.

An equal standard refers to ensuring that all people have access to a minimum standard of health care according to need, for example, universal access to basic health care. Equity of standards is “all about once a person has access to the health system that they have similar experiences in terms of treatment and care and have a similar health gain from those processes” (Eaves, 1998, p. 218).
Equity in health means all people with the same health care needs should receive the same amount and quality of health care. Smedley, Stith, and Nelson (2003) report minority groups receive lower quality health care, even when they are insured to the same degree and when other health care access-related factors are the same. Health disparities between majority and minority population have long been around for more than two centuries. Ethnic disparities exist for multiple and complex reasons.

Eaves (1998, p. 219) argues “equity of health cannot be the goal for the health service” because cultural and social influencing factors on health are outside of health professionals’ control. Thus factors such as individuals having different preferences, compliance patterns, health endowments, lifestyles and varied responses to treatments speak to the argument that equity of health cannot be the goal of the health service (Donaldson and Gerard, 1997). However, because the health service is not the single determinant of differences in health does not mean that it cannot influence both social policy and individual behaviour in order to narrow differences in health.

Although caring is a universal phenomenon, its manifestation is very much dependant on culture. For caring to be effectively received, the conceptualisation of caring at both individual and community level needs to be realised in practice. The debate on issue of cultural groups to date has concentrated on providing appropriate and equal services with some attention to minority groups’ health needs. It is unrealistic to expect health professionals to be experts in all cultures, but it is an expectation for the delivery of competent and appropriate care that culture is considered. Perhaps no other professional group in health care has recognised the impact of cultural diversity on its work as much as nursing. It is important, at all levels of nursing practice, to have a solid understanding of cultural diversity. Ethnocentric approaches to nursing practice are ineffective when dealing with the health and nursing needs of diverse cultural groups of patients (Hayes, 2000). Thus, learning about different cultures and their impact on health care is crucial for all nurses, whether they are working in a clinical setting, education, research or administration.
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2.4. Cultural Diversity in Nursing

2.4.1. Introduction to importance of the issue

Care of people from different cultural backgrounds is a challenging issue in nursing. At the start of a new Millennium, this has become more pronounced than ever before. The changing demographics and economics of our growing multicultural world and the long-standing disparities in the health status of people from culturally diverse backgrounds have challenged health care providers and organisations to consider cultural diversity as a priority.

‘Diversity’ is a term that means something different to each and every person. Cultural diversity addresses racial and ethnic differences, however, these concepts or features of the human experience are not synonymous. In addition to racial classification and national origin, there are many faces of cultural diversity. Religious affiliation, language, physical size, gender, sexual orientation, age, disability (both physical and mental), political orientation, socio-economic status, occupational status and geographical location are but a few of the faces of diversity.

Why is it necessary to study diversity? Why is it important for nurses to consider that cultures have values that must be taken into consideration? People increasingly are being forced to understand and live with the differences of others. Many nations are faced with not only trying to understand the diversity of others, but are engaged in tensions in an attempt to deal with the diversities. This is very evident in conflicts that have occurred in Ireland, Israel, Bosnia, the Middle East and Baltic countries, and most recently, with regard to the War on Terrorism.

Health professionals try to accommodate the changes in ethnic/cultural makeup of the population, religious differences, and inequities into health care based on educational, social, economical, environmental, and cultural factors (Alexander, 2002). As populations change and individuals become more transient, nurses are challenged everyday to incorporate the diverse needs of their clients into the provision of quality nursing care while facing the shortage in qualified staff to meet these needs.
During the past several decades, there has been an increased recognition of the need for developing culturally component care to diverse population (Purnell, 2004). Nurse theorists, such as Leininger, Davidhizar, Orque, Giger, Purnell, Campinha-Bacota, Paulanka, Andrews, and Boyle have researched cultural care for decades and instilled the need for nurses to look at diversity from the perspective of the client as they practice culturally competent care. Culturally competent care is becoming a 21st century imperative for those responsible for providing health care services in multicultural societies. All nurses need to find ways of dealing with a wide variety of complex clinical situations and caring for individuals in ways that do not conflict with patients’ beliefs and values (Hamilton, 2003; Meleis et al., 1995). Being treated in a culturally competent manner is a reasonable expectation of all of us in the new millennium. Nursing needs to evolve to where cultural awareness and diversity are engrained into nursing practice and the nursing consciousness.

Providing culturally competent health and nursing care is the key to improving practice at a time of diminishing resources in health and social care. Having cultural perspective helps nurses to deal with a very complex area. Cultural perspective provides a context for interpreting what nurses see in their patient to allow them to ask the right questions. It does not provide a list of facts about a cultural group, which can lead to stereotyping. Specific cultural facts are important but they need to be used with the understanding that every belief and behaviour has both a cultural and individual base. Nursing and nurses have taken leadership in defining and in developing models to address the culture care domains of different cultural background populations in culturally component and congruent ways (Leininger, 2002). Several numbers of models and approaches to cultural competence have emerged that help nurses to provide culturally sensitive care.

The following section will discuss the concept of cultural competence, describe models of cultural competence that can be used in the delivery of health care to address the many faces of diversity.
2.4.2. Cultural competence

‘Cultural competence’ has been defined as:

…a set of congruent behaviours, practices, attitudes, and policies related to embracing cultural differences that are integrated into a system or agency or among professionals. It is a state of being able to function effectively in this area (Mays, Siantz, and Viehweg, 2002, p. 139).

Cultural competence in health care refers to the ability of systems to provide care to patients with diverse values, beliefs and behaviours, including tailoring delivery to meet patients’ social, cultural, and linguistic needs. In literature, the terms, ‘ethnic nursing care, cultural care, cultural congruence, or culturally congruent care’, in essence are conceptually synonymous to cultural competence (Zuwang Shen, 2004).

In order to be culturally competent, health professionals need to understand both their own worldviews and those of the patient and avoid stereotyping and misapplication of scientific knowledge. Culturally competent care refers to using knowledge that has been learned about a specific culture and applying it in sensitive, creative, and meaningful ways when providing care to individuals from diverse backgrounds. Promoting cultural awareness among nurses is believed to improve their confidence and skills in providing holistic care for patients with different cultural backgrounds (Boyle, 2000).

Meyer (1996) describes four major challenges for providers in relation to cultural competency in healthcare. The first challenge is the recognition of clinical differences among people of different ethnic and racial groups. The second challenge is communication. This deals with everything from the need for interpreters to nuances of words in various languages. The third challenge is ethics. The final challenge involves trust. In order to deliver competent, compassionate, and high quality care, nurses must recognise, respect, and adapt to the diversity in all individuals using a model of cultural competence (Giger and Davidhizar, 1999).

Cultural competence models include cultural competence frameworks and cultural assessment frameworks. A number of theoretical models of cultural competence exist and are used in the process of developing appropriate nursing care to people from different cultural background. Cultural competence models developed by nursing
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researchers have been applied not only in nursing but also in other disciplines (Giger and Davidhizar, 2002; Purnell, 2004).

The next section presents a brief overview to the different models of cultural competence care. However it is not intended to be a complete, comprehensive critique of each one. In this section, Madeleine Leininger's Cultural Care Diversity and Universality Theory, Giger and Davidhizar's Model of Transcultural Nursing, Purnell's Model of Transcultural Health Care, Campinha-Bacote's Model of Cultural Competence, and The model of cultural competence by Papadopoulos, Tilki and Taylor are briefly introduced. The key elements of each are described, and the applications and limitations of each are outlined.

2.4.3. Cultural Competence Models in Nursing

2.4.3.1. Lieninger's Model

Leininger's Cultural Care Diversity and Universality theory and her Sunrise Model was the first nursing theory to focus on the role of culture in nurse-patient dynamics. Cultural care in diverse and similar cultural contexts is the central construct of the Leininger’s theory and the final goal of the theory in order to improve client care. This theory was created in the 1950s to advance transcultural nursing knowledge through the blend of the fields of anthropology and nursing (Andrews and Boyle, 2003). The aim of this transcultural approach is to identify both diverse and universal cultural components found among ethnic and social groups to help health professionals improve the care of patients from different cultural background (Benner and Wrubel, 1989). According to Leininger (Leininger, 2002), the theory of Cultural Care Diversity and Universality provides a new approach to assure culturally competent and congruent transcultural care.

The development of the theory is based on the defining of concepts by considering both culture specific and universal issues in order to give them a focus that emphasise the essence of care in its cultural context. For Hamilton (2003), transcultural nursing as:
a formal area of study and practice focused on comparative holistic cultural care, health, and illness patterns of people with respect to differences and similarities in their cultural values, beliefs, and compassionate care (Hamilton, 2003, p. 342).

Leininger claims transcultural nursing is a potentially relevant discipline with a unique body of knowledge to help nurses provide culturally competent care (Leininger, 1999). She distinguishes the term ‘cross-cultural’ from the term ‘transcultural’ and believes transcultural nurses do not use the term ‘cross-cultural’. However, this distinction between cross-cultural and transcultural nursing is an old argument that began in the 1960s (Andrews and Boyle, 2003).

The Sunrise Model of Leininger (1999) presents a framework for determining and understanding the unique sub-cultural group. Worldview, cultural values, and life ways are the major components of the Sunrise Model which are used in the analysis. The important social structure factors discovered included the environmental context, technological factors, religious and philosophical factors, political and legal factors, economic factors, and educational factors. Although Leininger’s Sunrise model has been used widely in nursing, the theory is complex and requires an understanding of how these factors interrelate.

Because Leininger acknowledges the similarities as much as differences in caring in regard to diverse cultures and recognises the comparative aspects of caring within and between cultures, the theory has a holistic approach and seeks to cover both the diversity and universality of concepts in patient care. The broad concepts and their qualitative dimensions make the theory relatively comprehensive and applicable in some contexts of multicultural care settings (Marriner-Tomey, 1994).

The Sunrise model of Leininger's with its emphasis on cultural sensitivity and cultural congruence has been criticised on the grounds that it believes that knowledge of different cultures would improve care and services (Culley, 1996; Culley, 1997). The cultural approach fails to account for the structural and political aspects of the inequalities of minority ethnic people (Mulholland, 1995) by focusing on cultural differences and deficits. From the perspective of cultural safety, the power relationship between the patient and the care professional is an important one, and it has been argued
that not to take into account the structural and political issues that affect people from minority ethnic groups is to diminish and disempower them, making the care less than culturally safe (Coup, 1996). For Leininger, cultural blindness, culture shock, culture imposition, ethnocentrism and cultural relativism are barriers to developing knowledge about other's culture.

2.4.3.2. Giger & Davidhizar’s Model
Giger and Davidhizar developed the Transcultural Assessment Model in 1988 in response to the need for nursing students in an undergraduate program to assess and provide care for patients from different cultural background (Davidhizar and Giger, 2004). The Giger and Davidhizar’s model focuses on assessment and intervention from a transcultural perspective that the person is seen as a unique cultural being. In this model, culture, ethnicity, and religion are three concepts which underpin the unique cultural being.

Giger and Davidhizar’s model consists of six cultural components, communication, time, space, social organization, environmental control, and biological variations. These cultural components provide a framework for patient assessment from which culturally sensitive care can be designed. Communication is the essence of being and embraces the entire world of human interaction and behaviour. Davidhizar and Giger (2004) consider the patient who speaks a different language needs communication approaches that meet with the cultural expectations of the patient.

For Giger and Davidhizar, space refers to the distance between individuals when they interact (Davidhizar and Giger, 2004). Spatial behaviour of patients and health professionals as well as the internal structural designs of hospital wards and departments convey needs that reflect cultural influences. Giger and Davidhizar consider social organisation that refers to the manner in which a cultural group organizes itself around the family group. Under the social organisation theme, it is recognised that culture should be considered in its totality (Davidhizar and Giger, 2004). They suggest that in order to understand culture-specific behaviours, “culture must be viewed and analysed as a totality, a functional, integrated whole whose parts are interrelated yet interdependent” (Davidhizar and Giger, 2004, p. 65).
According to Giger and Davidhizar (2004), another important aspect of interpersonal communication is time. Time is perceived, measured and valued differently across cultures. They discuss the concept of time with reference to the lifespan in terms of growth and developments, perception of time in relation to duration of events, and time as an external entity, outside our control (Davidhizar and Giger, 2004).

In the Giger and Davidhizar’s model, the ability of the person to control nature and direct factors in the environment that affect them refers to environmental control. They adopt a broad definition of the concept of environment and suggest that it is more than just the place where one lives, and involves systems and processes that influence and are influenced by individuals and groups (Davidhizar and Giger, 2004). They also think religious beliefs and experiences influence the everyday lives of people and beliefs about healing (Davidhizar and Giger, 2004) and impact on the perception of the individual and the natural environment, food, clothing, and medical interventions.

Davidhizar and Giger (2004) point out biological differences exist between individuals in different ethnic group. Although there is as much diversity within cultural and ethnic groups, knowledge of general baseline data relative to the specific group is an excellent starting point to provide culturally appropriate care. They outline biological variations across ethnic groups and believe in order to avoid generalisations and stereotyping, it is necessary to understand the biological variations of need (Davidhizar and Giger, 2004).

The model provides a comprehensive guideline for nurses to assess their patients from differing cultures in order to be aware of differences and to plan appropriate strategies. This model is appropriate for use with groups and individuals regardless of culture and is particularly useful and appropriate in multicultural societies where society is a mixture of people from different ethnic and cultural backgrounds (Davidhizar and Giger, 1997).

The Giger and Davidhizar model proposes a framework that facilitates that assessment of the individual. However assessment and intervention require previous knowledge of the cultural beliefs, values, and practices of the patient. Limitations of individual nurses may be exposed, however the need to learn may act as a motivation (Bolton, Giger, and Georges, 2003).
2.4.3.3. Purnell’s Model

Purnell (2002) conceptualised a model as a tool that provides an organisational framework for cultural data and is applicable to every culture. The model also provides a structure for health professionals to learn about different cultures. The Purnell model combines aspects of culture with the delivery of culturally sensitive health care to enable health professionals to view patients within their cultural context.

The concepts that make up Purnell's model of cultural competence are not unlike those found in Leininger's, and Giger and Davidhizar's models. However, Purnell's model extends some of the categories under which the concepts are organised. Purnell's model of cultural competence consists of two sets of factors that are described as the macro aspects and micro aspects. In the diagrammatic representation of the model, Purnell and Paulanka use concentric circles to locate the macroaspects and microaspects. The macroaspects form the wider outer circles and the microaspects the inner circle, all constituting segments of the whole (Purnell, 2002).

These domains are interrelated and provide for a comprehensive view of the individual. They include concepts that are common to the other models. The descriptive details this model reflects are to a large extent those that have been described earlier in Giger and Davidhizar's model. However, the domains of Purnell's model allow for a more focused analysis. Purnell (2002) provides guidelines to facilitate the further exploration of issues under each of these domains.

All health care providers in any practice setting can use the model, which makes it especially desirable in today's team-oriented health care environment. Used with a framework for nursing assessment, intervention and evaluation, the model can provide useful insight into the aspects of the person's cultural needs in relation to each domain. It can also provide explanatory models for health and illness across cultures (Purnell and Paulanka, 2003). Although the model is only few years old, it shows promise for becoming a major contribution to transcultural nursing and health care.

It is argued that there may be overlap as a result of common elements being present in any two or more of the domains, as well as in the domains and the macro aspects. The
model tries to be all-inclusive. The risk is that it may not be appropriate to practitioners unless the breadth and depth of their knowledge and skills is matched with the requirements of health care users.

2.4.3.4. Campinha-Bacote’s Model

In order to promote the inclusion of culture into nursing care, Campinha-Bacote (2002) created a model of cultural competence which defines cultural competence as “the process in which the nurse continuously strives to achieve the ability and availability to effectively work within the cultural context of a client individual, family or community” (Campinha-Bacote, 2003, p. 6).

Campinha-Bacote (2002) includes cultural awareness as the first component in her model of cultural competence. She states that cultural awareness is a process whereby health professionals become aware and learn to appreciate the beliefs, values, practices, and lifestyles of patients’ culture. For Campinha-Bacote, cultural desire involves the concept of caring. Cultural desire also involves the commitment of the nurse to care for all clients, regardless of their cultural values, beliefs, customs, or practices (Campinha-Bacote, 2002).

According to Campinha-Bacote, cultural knowledge is the process of seeking and obtaining an educational foundation about diverse cultural and ethnic groups. This process consists of four stages; unconscious incompetence, conscious incompetence, conscious competence, and unconscious competence (Campinha-Bacote, 2002). Campinha-Bacote (1999) states that cultural skill involves the ability to collect relevant cultural data regarding the patient's problem. In this model, cultural encounter refers to the process which encourages health professionals to directly engage in face-to-face interactions with patients from culturally diverse backgrounds (Campinha-Bacote, 1999).

Campinha-Bacote (2003) believes the model can be useful in caring for all people because in reality all people belong to the human race. Therefore they have the same basic needs. However Campinha-Bacote insists it is important to remember that these
needs may be expressed differently, and that quality health care service may mean something different for each patient.

### 2.4.3.5. Papadopoulos, Tilki and Taylor’s Model

Papadopoulos, Tilki and Taylor developed their model of cultural competence in 1998 in order to promote the inclusion of culture into the nursing curricula (Papadopoulos, 2006). According to Papadopoulos and Alleyne (1995), cultural competence is the synthesis of a lot of knowledge and skills and they defined cultural competence as the capacity to provide effective healthcare taking into consideration people's cultural beliefs, behaviours and needs.

The four stages of the model are cultural awareness, cultural knowledge, cultural sensitivity, and cultural competence. Cultural awareness begins with an assessment of the personal values and beliefs. Cultural knowledge can be achieved through a number of ways. Papadopoulos and Alleyne (1995) believe a meaningful contact helps health professionals to enhance their knowledge about people from different ethnic groups and understand their problems. In this model cultural sensitivity means how health professionals view people in their care. For Papadopoulos, Tilki and Taylor, the achievement of cultural competence requires the synthesis and application of previously gained awareness, knowledge and sensitivity (Papadopoulos and Alleyne, 1995).

Papadopoulos, Tilki and Taylor believe that the application of this model provides a structure which could improve the quality of care for all clients, irrespective of the type of health services clients may require (Papadopoulos, 2006).

### 2.4.4. Overview of culturally competent nursing

A shift in the population demographics has caused an increased interest in applying the principals of these theories to health care. Nurses frequently deal with cultural issues. The nurse in today's practice setting can have ten different patients of ten different nationalities or cultures.
Models of culturally competent care with established clinical approaches to clients from varying cultures are relatively new. It has been in the last three decades that nurses have began to develop an appreciation for the need to incorporate culturally appropriate approaches into the daily routine of client care. Boyle (2000) believes that models of culturally competent nursing, similar to any other theory, needs to be tested, refined, and changed to direct practitioner activities. However the usefulness of these models in another culture was tested in some studies (Corbie-Smith, 2004; Finn, 1995; Finn, 1993; Narayanasamy, 1999).

Wenger (1995) speaks of cultural competence as cultural openness in professional care contexts, achieved through cultural self-awareness and continuing development of transcultural skills. Transcultural nursing enables nurses to more accurately assess clients from different cultural background (Leininger, 2002). Transcultural nursing supporters believe the central concept of transcultural nursing is culture competency care. However transcultural nursing is a difficult topic to describe. Hamilton defined transcultural nursing as:

…a formal area of study and practice focused on comparative holistic cultural care, health, and illness patterns of people with respect to differences and similarities in their cultural values, beliefs, and compassionate care (Hamilton, 2003, p. 342).

From the health care perspective, the concept of transcultural accentuates an essential need for health system to provide holistic and culturally competent health care.

Andrews and Boyle (2003) point out that transcultural nursing can promote an awareness of cultural differences amongst people. Transcultural nursing facilitates nurses’ knowledge and skill in caring for people from diverse background. However Benner and Wrubel (1989) argue because of nursing practice does not render ethnocentric, thus it implies an acceptance of their validity by nurses. It also is argued the transcultural approach is deterministic, lacks explanatory rigor and omits pertinent structural factors from analysis. In its application such an approach will not necessarily promote delivery of appropriate and effective care but may compound the very problem it purports to address. The limitations of transcultural theory highlight the need for
nursing to evaluate any proposed innovation. Nurses can learn from other disciplines such as anthropology, but we must do so critically (Bruni, 1988).

In Australia, the Leininger model came to influence nursing education (Cameron, 1996). The Royal College of Nursing in Australia presented Dr Leininger with its first International Nursing Achievement Award. Regardless increasing the awareness of Australian nurses in terms of cultural influences on nursing education and practice, Gorman (1995) addresses the failure of the nursing profession in Australia as a multicultural society and argues that Australian nurses have failed to provide nursing services that meet the commitment of Australia to preserve cultural backgrounds because of misunderstanding of cultural differences and meet the needs of the people nurses serve. Gorman believes multiculturalism of Australia now exists and Australian nurses need to develop a sensitivity to and appreciation for the differences among cultures. There is still a tremendous need to provide advanced education to prepare Australian nurses in order to respond to a range of different needs, expectations and concepts related to health and illness (Gorman, 1995).

More recently a study was conducted by Pinikahana, Manias, and Happell (2003) in order to determine the availability of nursing models for undergraduate nursing students through searching Australian university websites on ‘transcultural nursing’ or related modules. Pinikahana argues that although the inclusion of these modules into nursing education provide an opportunity for nurses to perceive and respond to different patient behaviours in multicultural societies, it is not sufficient to understand the complexity of the health care needs of a multicultural society. The findings of Pinikahana’s study revealed many universities have not included transcultural nursing models in their nursing curricula. To address this problem, more transcultural nursing models need to be introduced into nursing curricula and nursing academics need to refine their attitudes about the importance of cultural aspects of patient care within nursing education (Pinikahana, Manias, and Happell, 2003).

Omeri (2004) conducted an inquiry into the state of culturally competent care in Australia and reported that multicultural nursing is currently addressed in nursing education in Australia at both the undergraduate and postgraduate levels. However Kanitsaki (1990) stresses that Australia’s cultural diversity has far reaching implications
for both Australia’s health care professions and for the Australian health care delivery system. She adds that “the major barriers to fulfilling the health care needs of Australia’s multicultural population were rooted in the attitudes of and lack of real cross-cultural knowledge and skills of the medical/nursing personnel” (Kanitsaki, 1990, p. 95).

It might be argued that whether or not transcultural nursing can help nurses to develop the learned objectivity and sensitivity needed to give culturally congruent care. Advocates for transcultural nursing believe transcultural nurses are leaders in promoting culturally competent care to improve understanding between staff and clients. The need for transcultural nursing principles and actions are imperative to care for people of diverse cultures (Cameron, 1996; Hamilton, 2003; McFarland, 1997). However the implementation of the principle of transcultural nursing has not yet become a reality in nursing (Cameron, 1996). Some nurses may believe that it is possible to work with people of different cultural backgrounds, without transcultural nursing preparation (Cameron, 1996).

Cameron (1996) critiqued transcultural nursing and says many nurses feel that it is not necessary for the specific needs of any group to be taken into consideration, but the fact is that nurses must be prepared to work with people from different cultural background. A review of contemporary nursing literature have demonstrated that nurses are rarely taught the concept of transcultural nursing in their training programs (Narayanasamy, 2003; Walsh, 2004). Thus it is agreed when they meet clients from culturally diverse backgrounds in the clinical setting they are often unable to accurately provide the kind of interventions that are culturally appropriate.

The demographic characteristics of Australia are rapidly changing as the nation becomes more culturally, racially, and ethnically diverse. Cultural diversity constitutes a great challenge to Australia’s health system. In light of these changes, it is crucially important to be aware of the cultural influences on nursing care when clients are from another culture. Although most health professionals are familiar with problems of the provision of care to people from different cultural backgrounds, and concern to understand the background of these populations and to the address their specific health needs, Allotey, Manderson, and Reidpath (2002) state health professionals describe
difficulties in providing proper care to individuals from diverse backgrounds when their own knowledge of these communities is not enough. To deal effectively with competing demands in a multicultural society, nurses need to be aware of transcultural nursing concepts. Therefore, transcultural nursing specific assessment and intervention strategies are needed for clients from a variety of cultural backgrounds. A number of concepts and models of transcultural care have been introduced. Whilst they are similar in the conceptualisations and processes that lead to the development of cultural competence the question of how these models are applicable into other cultures remains largely unanswered.

2.5. Experience of People from Minority Groups

The notion of cultural competence has been promoted for many years as the way for health professionals and health care systems to understand and respond effectively to the cultural and religious needs brought by patients to the health care encounter. Thus a better understanding of the relationship between culturally competent health services and patient experience and satisfaction is needed. These issues have not been more fully explored in preceding research. Recently published studies reinforce the intuition that a lack of attention to cultural issue leads to less optimal health care (Clark, Drain, and Malone, 2003; Griffiths et al., 2002; Yen, Chen, and Chou, 2002a).

Although some of health care will be provided in the outpatient clinic, because of the complexity of the disease and its management, it may be necessary to admit patients to various inpatient units. Each hospitalisation might be different. It varies because most of the time there are different doctors, nurses and other staff members and very different approaches. Each facility is different as well. Sometimes the programs change. Each hospital has its own set of rules and expectations of the patient. However they are some what similar. Some admissions are planned and others may be sudden, the result of an unexpected change in patients’ condition that requires direct observation and care. Hospitalisation for acute illness can be a traumatic experience yet little research has been conducted on the ways in which it impacts on patients.
Being in the hospital can potentially be a more stressful for people from minority groups due to many factors. Socio-cultural factors such as social network, language proficiency, modesty, socio-economic status, role expectations, folk beliefs and practices constructs influenced the hospital experience. Little information exists in the literature to assist the nurse in understanding people of ethnic minority group status who become hospitalised in an acute care setting. Research on these populations has primarily centred on outpatient service utilisation and on folk health practices, yet the process of becoming hospitalised seems far more disruptive and traumatic to the individual and the family than receiving health care at a clinic (Blockley, 2003).

The phenomenon of hospitalisation seems to be an inevitable situation and often a difficult experience. Many studies have been done in order to understand such experiences. However little is known about the experiences and perceptions of people from minority population hospitalisation in acute care settings. As a contribution to the development of this area, Yen, Chen, and Chou (2002a) used grounded theory in order to understand the experience of hospitalised patients from different cultural backgrounds in Taiwan. They described patients concerns in the six aspects that were generated from the results of the study. The hospitalisation experience was depicted as searching for certain aspects of health care needs focus on the physical condition, promptness and effectiveness of nursing services, health professionals caring attitudes when giving service and their responsibility, food preparation, environment, and medical expenses.

In Australia, Rice, Naksook, and Watson’s (1999) study, sought to describe the experience of postpartum care among Thai women in Melbourne. It depicted that most participants had varying views about the length of time they should spend in hospital and of the care they received. Moreover most Thai women showed varying ways of coping with the hospital environment in relation to their varying social situations.

Vydelingum (2000) used a phenomenological approach to explain the consumer's view of the 'lived experience' of acute hospital care from the perspectives of South Asian patients and their family. She found a duality in the experience of the participants, ranging from feeling of satisfaction with care to unhappy about the service. According
to the finding, Vydelingum points out that the study offers important insights into how South Asian patients survive their journey through their hospital stay. They believe these insights have implications for the provision of nursing care for minority ethnic patients. Griffiths et al. (2002) compared the expectations and satisfaction of German and Turkish immigrant women in terms of provided health care services. Although there was no significant difference between the two study groups in relation to their expectations of health care, the Turkish women were less satisfied as compared to the German women. In addition, communication with doctors and nurses and psychosocial services were perceived to be insufficient. Based on the findings of this research, Griffiths et al. state specific health-relevant factors, such as social and educational status, knowledge of German language and health knowledge together with structural deficiencies of a health care service that is not prepared to correspond properly to patients of different social and cultural backgrounds, have a negative impact on patient satisfaction for migrant women.

Tsianakas and Liamputtong (2002) examined satisfaction with care and services in relation to antenatal care and prenatal testing in order to improve antenatal care for women from an Islamic background. The finding of Tsianakas and Liamputtong’s study stated women had positive experiences with care relating to antenatal care and prenatal testing in Australia. However, the participants in this study indicated several issues of concern from an Islamic background. A lack of sufficient communication between health care providers and the women not only due to a language problem, but also a lack of cultural appreciation among health care providers and the issue of gender of health care providers as important were specific needs of these women. They suggest that in providing services for women of an Islamic background, it is imperative that health care providers take into account individual women's preferences and personal circumstances and go beyond an assumption based on women's religion and ethnicity.

Most researchers of patient’s experience of hospitalisation would agree that understanding cultural value systems is crucial for enhancing patient experiences. Although Islam is a respected religion in Australia, this review of the literature demonstrates that there has been little health care research about Muslims’ experience in Australian hospitals. Enhancing the knowledge base, skills and diverse belief systems of professional nurses is critical to the success of caring for the Muslim client. Providing
an accurate and effective nursing care to this group becomes possible through a clear understanding of the Islamic population from their vantage point (Carter and Rashidi, 2003).

### 2.6. Summary

In recognition of the growing diversity of our society, it is important for Australian nurses to expand their knowledge of other cultural belief systems. Since the numbers of Muslims in Australia are increasing, there is a need to develop an awareness of a culturally competent approach for this population in health care services particularly during hospitalisation. This review of the literature on patient’s experience of hospitalisation highlights that Islamic patients had experienced communication difficulties, inequity, and inappropriate care. The review however identified that the meaning individuals attribute to being a Muslim patient in an Australian hospital has not been explored in any study reviewed. This gap in the literature is the focus of the present study.

While nursing has some similarities in Eastern and Western countries, there are unique differences; if differences are discounted, it could interfere with the quality of care provided ethnic minority population. Nurses need to use a more holistic approach with a broader population. Nursing strategies must be sensitive to the cultural and spiritual beliefs of population from different cultural background. The culturally competent approach of nursing care is effective in providing the health needs of culturally diverse population in many ways.
CHAPTER THREE
RESEARCH METHODOLOGY

3.0. Introduction
This chapter describes the framework that underpins this research, which is grounded in existential and hermeneutic phenomenology as described by Heidegger (1967/1996) and Gadamer (1989/2003). Thus the focus of the chapter is on phenomenology as a research methodology, rather than to explore it as a philosophy. However, it is difficult not to offer some discussion of the philosophical foundation of phenomenology. Therefore, an overview of the development of phenomenology and some essential phenomenological elements are discussed within this chapter. Furthermore, the use of hermeneutic phenomenology as the methodology for the study is justified.

3.1. Phenomenology
Literally, the origin of the word phenomenology has its roots in the Greek terms ‘phaenesthai’ meaning to appear and ‘logos’ meaning reason. This etymology is central to understanding the meaning of phenomenology. Although the term phenomenology has become widely used, its meaning has become confused. Phenomenology is a
philosophical method dedicated to describing the structures of experience as they present themselves to consciousness, without recourse to theory, deduction, or assumptions from other disciplines such as the natural sciences. Sometimes phenomenology is viewed as a paradigm, sometimes as a philosophy or as a perspective, and it is sometimes even viewed as synonymous with qualitative methods or naturalistic inquiry, which refer to the process associated with the basic structure of lived experience (Polkinghorne, 1983).

Phenomenology is the name of a philosophical movement whose development has been most commonly associated with the Austrian-born German philosopher Edmund Husserl (1859-1938). Husserl believed that natural scientific approaches to inquiry did not provide a suitable means to understand the human being, as he believed man could not be reduced to a measurable object (Husserl, 1964). But Husserl himself did not provide a definition for phenomenology and rather presented it in terms of a philosophical perspective. Merleau-Ponty (1998) description of phenomenology is influenced by philosophical perspectives purported by Husserl.

Phenomenology is the study of essences; and according to it, all problems amount to finding definitions of essences … But phenomenology is also a philosophy, which puts essences back into existence, and does not expect to arrive at an understanding of man and the world from any starting point other than that of their facticity. It is a transcendental philosophy which places in abeyance the assertions arising out of the natural attitude, the better to understand them: but it is also a philosophy for which the world is always “already there” before reflection begins …It is the search for a philosophy which shall be a “rigorous science,” but it also offers an account of space, time and the world as we “live” them. It tries to give a direct description of our experience as it is, without taking account of its psychological origin and the causal explanations which the scientist, the historian or the sociologist may be able to provide (Merleau-Ponty, 1998, p. vii).

Sokolowski (2000) makes a distinction between two attitudes or perspectives that are often adopted. The first of these attitudes is the natural attitude, which refers to the focus or involvement in an original, world directed stance, where things, situations, facts and any other kind of objects are intended. The second attitude refers to a philosophical attitude, which requires a focus on a reflection on the natural attitude and all the intentionalities that occur within it. Thus the natural attitude refers to the physical
world in which we live and which we experience, it is the attitude of being in the world and of having objects or things manifest themselves to us (Sokolowski, 2000). Through the adoption of a philosophical attitude, phenomenology becomes a science that studies truth. It takes a step back from the rational involvement of the natural attitude and,

...marvels at the fact that there is disclosure, that things do appear, that the world can be understood and that we in our life of thinking serve as datives for the manifestation of things (Sokolowski, 2000, p.13).

In a more specialised sense, phenomenology attempts to depict phenomena appealing directly to the consciousness without taking into account its psychological origin or its casual explanation (Armstrong, 2004). Phenomenology thus means examining a phenomenon of the consciousness in its own dimension of consciousness. Perception is a key issue in phenomenological philosophy and method (Merleau-Ponty, 1998). Phenomenology seeks to understand how humans experience, make sense of and create meaning out of their existence. Consequently, the task of the phenomenological researcher is to describe the structures of experience, in particular consciousness, the imagination, relations with other persons, and the situatedness of the human subject in society and history (Crowell, 2002).

The aim of phenomenology is to describe lived experience and to seek a deeper understanding of how persons construct meaning. van Manen (1990, p. 19) states “The aim is to construct an animating, evocative description [text] to human actions, behaviours, intentions, and experiences as we meet them in the life-world.”

To further clarify both the philosophical and methodological perspectives of phenomenology, it is helpful to gain a sense of how the movement developed historically. The following section will present the historical foundation and development of phenomenology.
3.2. Foundation and Development

The history of phenomenology is complex. Phenomenology was not founded but instead existed, grew and continued changing over time. As often happens with philosophical traditions, its development was influenced by differing phenomenological schools, styles, and emphases (Armstrong, 2004). In describing the historical development of phenomenology, it can be presented within the four chronological phases of development.

The preparatory phase: Phenomenology began as a movement in philosophy that deals with the essences of objects, or phenomena as they present themselves in human consciousness. The very beginning of phenomenological thinking could be considered to have taken root in the attempt by Rene Descartes (1596-1650) to determine what could be known with certainty (Moustakas, 1994). According to Sokolowski (2000), the word phenomenology was being used in philosophy as early as 1765 and it can be found occasionally in the writings of the philosopher Immanuel Kant (1724-1804). However, Pivcevic (1970) wrote that phenomenology as a word came only into prominence around 1807 when George Hegel (1770–1831) published his book, phenomenology of the spirit, as an introduction to his system of philosophy. The basic approach of phenomenology was first developed by Franz Brentano (1838–1917). Brentano supposed that the central concern of philosophy is to understand the nature and content of awareness in ways that illuminate the distinction between the mental and the non-mental (Taylor, 1982).

German Phase: The second phase of the phenomenological movement included both Edmund Husserl (1859-1938) and Martin Heidegger (1889-1976). Husserl, Brentano’s student, held Professorships at Gottingen and Freiburg Universities in Breisgau and wrote ‘The Idea of Phenomenology’ in 1906, is known as the father of phenomenology. Husserl (1964) believes in the researcher’s intuitive understanding of human experience. To reach an intuitive understanding, researchers must become immersed in the phenomenon and become aware of their own and other’s people perception of the phenomenon. Husserl (1964) defines phenomenology as a descriptive analysis of the essence of pure consciousness and describes pure or transcendental phenomenology as
an ‘eidetic’ science. He distinguishes between transcendental phenomenology and empirical subjectivity, which is based on empirical facts (Armstrong, 2004). Phenomenology, as formulated by Husserl, is the study of the structures of consciousness that enable consciousness to refer to objects outside itself.

Martin Heidegger built on the work of Husserl. Heidegger applied the methods of phenomenology to ontology, the subject of existence. While Husserl was concerned with epistemology, Hiedegger focused on more general concept of understanding. According to Heidegger (1967/1996), when we study our relationship to the world, we should not just study the way we look upon it as being out there, outside consciousness. We should study the way we lived in the world, giving it meaning through our actions, the world indeed being nothing other than a meaning structure lived in by us, and ultimately identical with ourselves.

Hans Georg-Gadamer (1900-2002), Heidegger’s student, developed philosophical hermeneutics. Gadamer (1989/2003) argues that hermeneutic, the science of interpretation, is not only a method of determining truth but it is an activity which aims to understand the conditions that make truth possible. According to Gadamer (1989/2003), the role of hermeneutic in human sciences is not the same as the methods of research in the natural sciences, which transcends the concept of method. The truth of spoken or written language may be revealed when we discover the conditions for understanding its meaning (Gadamer, 2003).

French phase: The third phase of the phenomenological movement began in France. Gabriel Marcel (1889-1973), Emmanuel Levinas (1906-1995), Jean Paul Sartre (1905-1980), and Maurice Merleau-Ponty (1908-1961) were the predominant leaders of the French phenomenological movement. Sartre expressed a belief in individuals’ total freedom and complete responsibility for their own world (Cohen, 1987). Merleau-Ponty advanced the notion that by using a phenomenological approach to examine perception, researchers could gain greater understanding of the lived experience (Merleau-Ponty, 1998). Unlike Husserl, Merleau-Ponty focused on the world-referring structures of perception rather than the internal organisation of consciousness. His phenomenology is
unique in that he explicitly affirms the reality of the world external to consciousness. Thus much of his philosophy consists of a refutation of certain idealistic suppositions that characterise classical phenomenology (Compton, 1998).

Following the initial period of the phenomenology movement in French philosophy, there was a period of creative development within the philosophical arena. This was phenomenology existentialism (Streubert Speziale and Carpenter, 2003). Existentialism is a philosophical movement closely linked with phenomenology that developed during the nineteenth and twentieth centuries. Existentialism is described as a tendency, emphasising individual existence, freedom, and choice (Jacobs, 1975). One of the first things one may notice about existentialism is the confusion and disagreement of what it actually is. Because of the diversity of positions associated with existentialism, the term is impossible to define precisely. Certain themes common to virtually all-existentialist writers can, however, be identified (Todres and Wheeler, 2001).

Recent phase: Although phenomenology began as a philosophical method of inquiry in Continental Europe, there is evidence of phenomenology, especially philosophical phenomenology, in Australia and the North America during the 1920s. Phenomenology has found appeal amongst North American philosophers, chiefly the work of two scholars at the New School for Social Research in New York, Alfred Schutz (1899-1959), an Austrian-born sociologist and student of human cognition, and Aron Gurwitsch (1901-1973), a Lithuanian-born philosopher that influenced Merleau-Ponty.

According to Silverman (1987), it is imperative to differentiate between American and European phenomenology. Two major differences exist between the American and the traditional European approaches to phenomenology. Firstly, there is a different emphasis on experience within each approach. Traditional phenomenology insists on pre-reflective experience whilst American phenomenology intends to explore experience by itself. Secondly, there is a different approach to the role of culture. American analysis focuses on describing participants’ situated experiences, which are within the context of their culture, rather than on searching for the universal or unchanging meaning of experiences outside the cultural context. The difference in the way culture is viewed indicates that some of the assumptions that underlie traditional
and American phenomenology are different. In traditional phenomenology, the
assumption appears to be that phenomena have universal meanings that may be inherent
in phenomena from culture to culture, almost a universal truth value, as it were. In
American phenomenology, although it is not stated, the underlying assumption appears
to be that phenomenal meanings are culturally constructed and therefore may be found
in descriptions of experience by itself (Caelli, 2000).

### 3.3. Phenomenological Research

Most phenomenological approaches of inquiry draw on German philosophy, in that they
seek to understand the life world or human experience as it is lived (Laverty, 2003), and
have similar and complementary end-points in description (Hein and Austin, 2001).
There are three phenomenological schools or movements (transcendental
phenomenology, existential phenomenology, and hermeneutic phenomenology) that
represent philosophical assumptions about experience and ways to organise and analyse
phenomenological data. Pure or transcendental phenomenology is most clearly
identified with the ground breaking work of Husserl and his collaborators. Existential
phenomenological research is associated with Heidegger, Sartre, Merleau-Ponty, and
Marcel. Hermeneutic phenomenological research is linked particularly with Heidegger,
Gadamer, and Ricoeur. The following section attempts to explore the philosophical
orientation of these phenomenological schools of thought. This exploration will begin
with the transcendental phenomenology and existential phenomenology and then move
to explore hermeneutic phenomenology through Heidegger and Gadamer. Exploration
will be given to how these different philosophical perspectives have an impact
phenomenology as a research methodology.
3.3.1. Pure or transcendental phenomenology

‘Transcendental phenomenology’ is descriptive in nature, seeking to explore and describe phenomena as they present themselves in the lived world in order to find meaning of the phenomena for itself (Jordan, 1981). Pure phenomenology, which has matured into transcendental phenomenology, has its origin in philosophy (Giorgi, 1997) and is situated within the positivist and post positivist paradigm.

In brief, transcendental phenomenology allows investigators to understand and express the necessary relationship between data of empirical investigation and the concepts used to organise and direct these data (Husserl, 1964). Transcendental phenomenology emphasises subjectivity and the discovery of the essences of experience. Armstrong (2004, p. 5) maintains that:

Husserl viewed consciousness as a co-constituted dialogue between a person and the world. Moreover, he saw access to the structures of consciousness not as a matter of induction or generalization, but as a result of direct grasping of a phenomenon. This grasping was seen as an intentional process, actively guided by human intention, not mechanistic causation.

Edmund Husserl, the founder of phenomenology, sought to make philosophy a rigorous science by returning its attention to the things themselves. Husserl (1964) believed that phenomenology was the study of the structures of consciousness that enabled consciousness to refer to objects outside itself. This study requires reflection on the content of the mind to the exclusion of everything else. Husserl (1964) called this type of reflection, phenomenological reduction. Because the mind can be directed toward nonexistent as well as real objects, he noted that phenomenological reflection does not presuppose that anything exists, but rather amounts to a bracketing of existence, that is, setting aside the question of the real existence of the contemplated object. Therefore, he advocated that there is an indissoluble unity between the conscious mind and that of which it is conscious (Armstrong, 2004).

Husserl (1964) introduced the term, pure phenomenology. Basically, this philosophical method concentrates on the careful analysis of conscious human experience, without considering questions of their causes, their objective reality and metaphysics or even
other traditional philosophical issues (Kleiman, 2004). The main focus for Husserl was the study of phenomena as they appeared through consciousness.

van Manen (1990, p. 9) states “Consciousness is the only access human beings have to the world”. Using a phenomenological approach, to explore a given phenomenon in the life-world is to explore it first as it is presented to the consciousness of a person, within the context of their life-world. Anything that presents itself to consciousness is potentially of interest to phenomenology, whether the object is real or imagined, empirically measurable or subjectively felt. Giorgi (1997) states those things that present themselves in the lived world, need to be part of the consciousness of a person, for them to be spoken of or referred to. Their presence is acknowledged through conscious and intentional recognition. Without being conscious of the presence of a thing, it cannot be part of the life-world of a person. The fundamental structure of the concept of consciousness is intentionality.

van Manen (1990, p.184) defines the concept of ‘intentionality’ as “the inseparable connectedness of the human being to the world”. Intentionality is one of the essential concepts of phenomenology. As it is at this point that phenomenology begins. Intentionality is the defining characteristic of phenomenology. This foundational characteristic establishes and highlights primary sources of human interaction in the world. For Husserl, intentionality means people constitute their world and their reality intentionally. Without a thorough understanding of intentionality, any discussion of phenomenological investigations would be severely limited and criticised (Jordan, 1981).

Husserl borrowed the notion of intentionality from Brentano in order to explain the intentional structure of all consciousness (Armstrong, 2004). Understanding and phenomena are attained through intentional conscious experience of phenomena and are as a description of reality. In fact, the intentionality of consciousness is the most important element of Husserlian phenomenology. By intentionality Husserl asserted that all human activity about things in the world was always oriented activity, that conscious awareness was always intentional awarenesses and that consciousness was in itself, consciousness-of-something (Ping-Kenug, 2004). The orientation to intentionality
however, is not always conscious. Intentionality is only available to consciousness upon retrospective reflection.

Husserl emphasised that phenomenology is concerned with the essence of what is immanent in consciousness, and that it is concerned with describing immanent essences (Husserl, 1964). Thus an important step in Husserlian phenomenological philosophy was reflection on the meaning, or ‘essence’, of the experience of consciousness. In phenomenology the essence of phenomena is its essential meaning before social and cultural meanings are attached to it. Within this contention of transcendental phenomenology, the given object is of central importance, its character must be described rather than explained, with the description aiming at an intuitive grasp of the essences embodied within the experience (Moustakas, 1994).

van Manen (1990, p. 10) defines essence as that “which makes a thing what it is”. He claims the essence of a phenomenon is universal, and can be described through a study of the structure that governs the instance or particular manifestations of the essence of that phenomenon. Jennings (1986, p.1232), who wrote about Husserl’s philosophical aims, defined essence as:

... a fact or entity that is universal, eternally unchanging over time, and absolute ... [It] is not relative to a given culture or historical age, is not restricted to personal opinion, and it not dependent on logical arguments.

Essences do not exist apart from the conscious experience of beholding them. Jennings (1986) acknowledged that they are not floating around waiting for the mind to behold them and thereby actualise them as real, but rather are grasped in an act of reflective consciousness.

Husserl often used the words transcendental and pure phenomenology interchangeably to describe the special method of the eidetic reduction by means of which the phenomena are described. ‘Phenomenological Reduction’ is an important concept within Husserlian phenomenology. It relates to the process where the researcher adopts a scientific attitude and steps back, to examine and describe the phenomenon (Giorgi, 1997).
Through phenomenological reduction, the researcher seeks to determine the pure essence of the phenomena by taking a detached or neutral standpoint so that the phenomena can be viewed with a clear mind (Walters, 1995). These steps could become guideposts to the reflective practice of the observer. Jennings (1986, p. 1237) argues nothing is ‘lost’ through this reductive process but that is “… strictly a methodical move to temporarily strip the world of the multitude of implicit presuppositions about its existence as ‘real’, thereby allowing aspects of the world to recur as ‘pure phenomena’ for consciousness.”

Consequently, transcendental phenomenology, according to Husserl, is the scientific study of various types of experience or phenomena, ranging from perception, thought, memory, imagination, emotion, desire, and volition to bodily awareness, embodied action, and social activity, just as they are seen and appear in consciousness (Armstrong, 2004). It requires reflection on the content of the mind to the exclusion of everything else. Husserl called this type of reflection the phenomenological reduction. Because the mind can be directed toward nonexistent as well as real objects, Husserl noted that phenomenological reflection does not presuppose that anything exists, but rather amounts to a bracketing of existence that is, setting aside the question of the real existence of the contemplated object. Husserl claimed that with the use of phenomenological reduction, we are able to uncover and describe the fundamental structures of our life-world (Husserl, 1964).

Edmund Husserl was instrumental in the formulation of today’s modern view of phenomenology. Yet, even for Husserl, the conception of phenomenology as a new method destined to supply a new foundation for both philosophy and science developed only gradually and kept changing to the very end of his career (Seamon, 2000). It is transcendental because it adheres to what can be discovered through reflection on subjective acts and their objective correlates (Moustakas, 1994). It also provides a systematic and disciplined methodology for the derivation of knowledge and utilises only the data available to consciousness, that of the appearance of objects.
However other phenomenological thinkers such as the German philosopher Martin Heidegger and the French philosopher Maurice Merleau-Ponty reacted against Husserl's transcendental structures of consciousness (Merleau-Ponty, 1998; Heidegger, 1993). These existential philosophers, as they came to be called, argued that such transcendental structures are questionable because Husserl based their reality on speculative, cerebral reflection rather than on actual human experience taking place within the world of everyday life (Schmidt, 1985).

3.3.2. Existential phenomenology

‘Existential phenomenology’ is “a combination of the phenomenological method with the importance of understanding man in his existential world” (Cooper, 1999, p. 5). Existential phenomenology is a version of phenomenology that problematises human existence. “What are the structures of the human” is a question that an existential phenomenologist may ask (Cooper, 1999, p. 5).

Through an existential phenomenological investigation, one makes the familiar come to the fore by virtue of pointing out that its familiarity has rendered it invisible as an object of reflection. In addition, such analyses explore the intersubjective framework of meanings and the impact of multiple intentions and sociality. Phenomenology distinguishes between interpreting ontological judgments and making them (Farber, 1967).

The most influential existential phenomenologists have been the German philosopher Martin Heidegger and the French Philosopher Jean-Paul Sartre. Classification of some other thinkers like Maurice Merleau-Ponty, Hans-Georg Gadamer, or van Manen under these two labels is not easy. They, like Sartre, used the concept of phenomenology in their writings, but they changed the emphasis of their study from the strictly epistemological stance of being towards an ontological stance that is about understanding the human life-world (Compton, 1998).
Sartre expanded further on Husserl’s phenomenology by introducing a reflexive and
pre-reflexive consciousness (Spiegelberg, 1982). Although Husserl perceived the task of
transcendental phenomenology to describe the lived world from the viewpoint of a
detached observer, existential phenomenology insists that the observer cannot separate
himself from the world (Heidegger, 1993). Existential phenomenologists followed out
more rigorously the implications of the doctrine of intentionality of consciousness
(Gadow, 1980). For existential phenomenology, the modalities of conscious experience
are the ways one is in the world. This shift of the notion of the lived-world to the
emphasis upon Being-in-the-world expanded phenomenology in a way that allowed it to
consider the totality of human relationships in the world in terms of the individual's
concrete existence (Merleau-Ponty, 1998).

Two concepts that existential phenomenologists investigate are ‘lived experience’ and
‘Being-in-the-world’ (Compton, 1998). The concept of ‘lived experience’ is that which
is lived by a person at a given time, in a given place. It is pragmatic and implicates the
totality of life and is already there and is part of our awareness (van Manen, 1990; van
Manen, 1997). Dilthey (1987, p. 35) says:

A lived experience does not confront me as something perceived or
represented; it is not given to me, but the reality of lived experience is there-
for-me because I have reflexive awareness of it, because I possess it
immediately as belonging to me in some sense. Only in thought does it
become objective.

According to Dilthey (1987), lived experience involves our immediate, pre-reflective
consciousness of life. The term ‘pre-reflective’ in this context means, the immediately
sensed perception of lived experience (Merleau-Ponty, 1998). Lived experience within
the life world lies at the very heart of phenomenology, without it there would not be
phenomena to investigate. van Manen (1990, p. 36) states “lived experience is the
starting point and the end point of phenomenological research.”

‘What does it mean to be a person?’ By asking this ontological question Heidegger
aimed to reveal “the nature and meaning of Being”, that is what it means to be a human
being within the world (Crotty, 1996, p.76). The concept of ‘Being-in-the-world’ relates
to the individual’s world of their everyday life. It has been suggested that Heidegger
intended this phrase, with the purposeful use of the hyphens, to indicate that “…the expression should be viewed as a unified phenomenon …” and that the components “Being-there” and “in-the-world” can only be viewed by viewing the effect that one has on the other (Walters, 1995, pp.30-31). Heidegger (1996) used the German term ‘Dasein’ to denote the being to whose being and understanding of being belongs. Indeed the German translation of Dasein simply means “existence” (Leonard, 1994, p.42). In other words, the concept of ‘Being-in-the-world’ is the world as lived by a person, a whole being, complete with worldview, relationships and experiences. For Heidegger, ‘Being-in-the-world’ precedes all our thinking of the world and ‘Dasein’ should be the starting point for all questions about ‘Being’ (Giorgi, 1997). This concept attempts to express that the person and environment are one and the same thing. Each individual’s life-world is different, and individual’s actions can be understood by situating themselves within their own life-world (van Manen, 1990/1997).

‘Being-in-the-world’ is existentialism's attempt to avoid reference to human reality in terms either of a thinking substance or a perceiving subject closed in upon itself facing physical objects which may or may not be knowable. ‘Being-in-the-world’ refers exclusively to human reality in contrast to nonhuman reality, and although the specific terminology has varied among existentialists, common to all is the insistence that human reality is situated in a concrete world-context. In short, man is only man as a result of his actions which are worked out in the world. However, there is still the reciprocal relationship that phenomenology insists upon which implies that the total ensemble of human actions, including thoughts, moods, efforts and emotions, define the context in which man situates himself and in turn, the world-context defines and sets limits to human action (Stewart and Mickunas, 1990).

3.3.3. Hermeneutic phenomenology

‘Hermeneutics’ is derived from Greek verb, ‘hermeneueuin’, to interpret (van Manen, 1997) which in the Greek language refers to an explanation or translation (Crotty, 1998). The word was derived from Hermes, who in Greek mythology was the wing-footed messenger god responsible for the discovery of language and writing through
which he changed the unknowable into a form that humans could grasp and understand (Thompson, 1990). From the historical viewpoint, the term of hermeneutics dates from 17th century and the actual activity of hermeneutics, which is textual interpretation, dates back to the period after the Renaissance (Polkinghorne, 1983). In the context of hermeneutic phenomenology, van Manen (1990/1997) points out that the term acquired a much broader significance in its historical development and finally became a philosophical position in 20th century German philosophy.

Hermeneutics is the art of interpretation and a type of philosophy that starts with questions or interpretation (Audi, 1999). Text includes any discourse that is transcribed as well as written description of behaviour. Interpretation is the process of moving beyond mere description of a phenomenon or the cataloguing of currently accepted subjective interpretations. The text created from transcription of the discourse contains ordinary language. van Manen (1990, p. 61) maintains that:

Ordinary language is in some sense a huge reservoir in which the incredible variety of richness of human experience is deposited. The problem often is that these deposits have silted, crusted or fossilised in such a way that the original contact with our primordial experiences are broken.

There exists a close relationship between hermeneutics and phenomenology. The German philosopher Martin Heidegger has been influential in both the phenomenological movement and the development of modern hermeneutics (Laverty, 2003). He defined phenomenology as an analysis by which the meaning of the various way in which we exist can be translated from the vague language of everyday existence into the understandable and explicit language of ontology without destroying the way in which these meanings manifest themselves to us in our everyday lives (Laverty, 2003). Heidegger (1993, p. 193) wrote:

In interpreting, we do not, so to speak, throw a signification over some naked thing which is present-at-hand, we do not stick a value on it; but when something within-the-world is encountered as such, the thing in question already has an involvement which is disclosed in our understanding of the world and this involvement is one which gets laid out by the interpretation.
In fact, Heidegger moved from the epistemological basis of Husserl’s work in which intentional acts were individual, to the ontological basis of hermeneutics and further refined the notion of intentionality (Richardson, Richardson, and Heidegger, 2003). Heidegger (1996) took intentionality out of the context of a theory of meaning to a theory of being. Heidegger came to view intentionality not as a determined act but as the constitution of consciousness itself. Consciousness to Heidegger was not an interior thing but a going out or projection from oneself (Kockelmans, 1994).

There are two positions in hermeneutics, the first being informed by Wilhelm Dilthey (1833-1911) who proposed interpretation as a method for the historical and human sciences. The second approach was informed by Heidegger who saw it as an ontological event, a reflective interpretation of a text or a study in history to achieve a meaningful understanding (Moustakas, 1994). This led to the development of a method that would return to the text and clarify the principles of interpretation that were intrinsic to the text.

Hermeneutics is an interpretive method of inquiry. It can be described as the science of interpretation or understanding (Kockelmans, 1994). The aim of hermeneutics renders the outcome of interpretation. According to Heidegger (1996), there is no escape from the historical foundation of our understanding because it serves as an ontological base for our Being-in-the-world. In spite of transcendental phenomenology, which tends to disregard history, hermeneutics considers it to be essential to its discipline. Hermeneutics could be considered to refer to the interpretive process which the researcher goes through in order to gain knowledge and understanding and therefore give meaning to the phenomena. This interpretation is achieved by the researcher through an application of the hermeneutic circle (Laverty, 2003).

Gadamer, a student of Heidegger, extended the existential, ontological exploration of understanding by placing emphasis on the study of language (Koch, 1995a). He also presented a phenomenological view that denounced the notion of the scientific method as the exclusive avenue to truth. Unlike Husserl, Gadamer follows his teacher Heidegger in recognising that the ties to one's present horizons, one's knowledge and
experience, are the productive grounds of understanding. He believed that there could be no understanding without prior knowledge (Fleming, Gaidys, and Robb, 2003).

For Gadamer (1989), understanding recreates the initial intention embodied in the text, by clarifying the subject matter that the text addresses. Gadamer (1989) maintains that all understanding includes a measure of interpretation and that understanding and interpretation cannot be separated when engaging a text. In his philosophical hermeneutics, there is an inherent truth to be discovered in text, and this truth is a perfect unit of meaning. The dialogue is grounded in the concern which the interpreter shares toward a common question and a common subject matter. In confronting a viewpoint reflecting a different set of horizons, the interpreter can find his own horizons highlighted and reach critical self-consciousness. In seeking the key question, the interpreter repeatedly transcends his own horizons while pulling the text beyond its original horizons until a fusion of the two horizons occurs. The interpreter's imagination can also play a role in the dialogue with texts and carry the understanding of the subject matter beyond the finite interpretation realised in methodological hermeneutics.

Hans-Georg Gadamer stated that factors such as history and tradition, as well as factors such as the interpreter’s aims, methods and themes, influence their interpretation of the text (Gadamer, 1989). He recognised not only the subjective nature of the text, but also the subjective nature of the interpretation of the text. Hermeneutics thus recognises that people live within and create meaning through the social, cultural and historical context in which they are embedded, and through which they make sense of their world. Therefore understanding and meaning, for Gadamer, results not only from the text, but also through the interaction between the text and the interpreter located in their own life world, larger cultural context and historical point in time (Fleming, Gaidys, and Robb, 2003).

**The Hermeneutic circle:** Gadamer accepts the notion of the hermeneutic circle, where we must “understand the whole in terms of the detail and the detail in terms of the whole” (Gadamer, 1989, p. 29). The hermeneutic circle involves a movement between the specific and the whole, between projection of meaning and anticipation of understanding. The aim of this process is to uncover and explicate an understanding of
the phenomenon. Heidegger uses the metaphor of the hermeneutic circle to represent the dynamic movement between the parts and the whole of texts to seek understanding. Therefore, the meaning of the parts depends on the whole, and the meaning of the whole depends on the meanings of the parts. This understanding takes an ontological position of understanding, not as a way of knowing (Annells, 1996).

The circle consists of two arcs. Both arcs are equally important in hermeneutics. The forward arc is one of projection. This makes understanding possible. The arc projects from a pre-understanding. Gadamer (1989) referred to this understanding as prejudice. In hermeneutic phenomenology, pre-understanding is a structure for being in the world. This is the point of entering the circle. This pre-understanding is primarily of a practical as opposed to a conceptual nature. Laverty (2003) described pre-understanding as the meaning and organizing process. She states that:

This pre-understanding is the meaning or organization of a culture that are present before we understand and become part of our historicality of background. Pre-understanding is not something a person can step outside of or put aside, as it is understood as already being with us in the world. Heidegger went as far as to claim that nothing can be encountered without reference to a person’s background understanding (p. 8).

According to Gadamer (1989), a movement toward understanding consists not only of remaining open to meaning, but also of fore-projection or developing an early understanding of what has been said. In attempting to understand the story of another, the movement of understanding is constantly from the whole to the part and back to the whole again. Thus, the circle of understanding is not a methodological circle, but describes an element of the ontological structure of understanding or being (Gadamer, 1989). The hermeneutic task becomes of itself a questioning of things, whereby early understandings or fore-projections become replaced by more suitable projections, as it becomes clear what the meaning is. In other words, fore-projections are constantly revised as new meanings emerge from the text, constituting the movement of understanding and interpretation (Gadamer, 1989).

**Prejudice and dialogue with the text:** An important distinction to be made regarding the nature of understanding ‘Being’ is that, in Gadamerian phenomenology, objectivity
consists not in avoiding preconception but in its confirmation. As we have seen, interpretation of lived experience begins with an assumption of familiarity and proceeds to listening with openness to the unexpected and a readiness to revise our preconceptions (Gadamer, 1989). Gadamer believes “A person trying to understand a text is prepared for it to tell him something” (Gadamer, 1989, p. 269). Within the notion of understanding, it is important to be aware of one’s own bias, so that the text can present itself in all its otherness, thus asserting its own truth against one’s own fore-projections (Gadamer, 1989).

**Fusion of horizons:** Gadamer explains that our horizon is something that moves with us, rather than something into which we move, adding that when we find ourselves in situations that we wish to understand, our task is to throw light into it. This task is never entirely finished, thus it can be seen that we have an infinite capacity to refine and extend our understanding of things. Gadamer determines that fusion of horizons occurs when our own horizon is understood in order to understand that of another. He adds that an act of understanding occurs when there is a conscious act of fusing two horizons, creating historical consciousness (Gadamer, 1989).

**Understanding of the phenomenon:** Gadamer extended the existential, ontological exploration of understanding through placing emphasis on the study of language (Koch, 1995a). He also presented a phenomenological approach that criticised the notion of the scientific method as the exclusive path to truth. Unlike Husserl, Gadamer strongly disagreed with the idea that experience could be studied from the position of a neutral observer, detached or removed from the immediacy of experience. Armstrong (2004, p. 166) states, “Gadamer’s argument rests strongly in his detailed critical analyses of previous thinking about language, historical consciousness and the aesthetic”.

A fundamental aspect of Gadamer’s phenomenology is the rejection of the notion of subject-object (Roy and Starosta, 2001). For Gadamer,

> The purpose of my investigation is to discover what is common to all modes of understanding and to show that understanding is never a subjective relation to a given object but to the history of its effect; in other words,
understanding belongs to the being of that which is understood (Gadamer, 1989, p. xxxi).

Gadamer (1989) also believes that pre-understanding is a condition and necessary part of understanding. According to Gadamer, we must be situated in the world before understanding can occur. Weinsheimer (1985, p. 11) points out that “We understand the world before we begin to think about it; such pre-understanding gives rise to thought and always conditions it”.

From Gadamer’s perspective, hermeneutics concerns itself with freedom of the individual. Openness to meaning in Gadamerian phenomenology underpinned the approach to the study participants. Gadamer asserts that openness to meaning is fundamental to understanding. Openness to meaning is keeping one’s self open to what is other and embracing more universal points of view; or detaching one’s self from one’s immediate desires and purposes (Gadamer, 1989). Openness to meaning was manifest in the decision to undertake interviews that used an open-ended, non-linear approach. It was conversational in nature, when interacting with the participants of the study (Geanellos, 1999). However, this is not to suggest that the interviews were without intent or object.

### 3.4. Methodological Issues

Important distinctions, which are apparent in methodology, provided for shifting away from transcendental phenomenology and moving toward a hermeneutic phenomenology in this research. Transcendental phenomenological research is descriptive and focuses on the structure of experience, the organising principles that give form and meaning to the life world. It seeks to explain the essences of these structures as they appear in consciousness. Hermeneutic phenomenological research is interpretive and concentrated on historical meanings of experience and their developmental and cumulative effects on individual and social levels. This interpretive process includes explicit statements of the historical movements or philosophies that are guiding interpretation as well as the presuppositions that motivate the individuals who make the interpretations.
(Polkinghorne, 1983). While Allen (1995) argued that a clear distinction between transcendental phenomenology and hermeneutic phenomenology does not exist, he describes phenomenology as foundationalist, as it seeks a correct answer or valid interpretation of texts not dependent on the biographical, social or historical position of the interpreter. Hermeneutic phenomenology, in contrast, is described as non-foundationalist, as it focuses on meaning that arises from the interpretive interaction between historically produced texts and the reader.

In comparing transcendental phenomenology and hermeneutic phenomenology as research methodologies, similarities and differences exist that arise out of the philosophical bases of these traditions. It is interesting to note that while the focus and outcomes of the research, including data collection, subject selection, and the understanding of the lived experience, may be similar, the position of the researcher, the process of data analysis, and the issues of rigor or credibility can provide striking contrasts between these methodologies. While the methodological issues described herein are presented in a structured fashion, it is important to note that the process itself is more often than not cyclical rather than linear in both transcendental phenomenology and hermeneutic phenomenology.

When a decision to engage in research of a particular experience from a hermeneutic or phenomenological perspective is made, the researcher begins a process of self-reflection. For the phenomenologist, this is typically part of the preparatory phase of research and might include the writing down of these reflections for reference during the analysis process (Polkinghorne, 1989). The purpose of this reflection is to become aware of one’s biases and assumptions in order to bracket them, or set them aside, in order to engage the experience without preconceived notions about what will be found in the investigation. This awareness is seen as a protection from imposing the assumptions or biases of the researcher on the study. In contrast, a hermeneutical approach asks the researcher to engage in a process of self-reflection to quite a different end than that of transcendental phenomenology. Specifically, the biases and assumptions of the researcher are not bracketed or set aside, but rather are embedded and essential to interpretive process. The overt naming of assumptions and influences as key contributors to the research process in hermeneutic phenomenology is one
outstanding difference from the naming and then bracketing of bias or assumptions in transcendental phenomenology.

Gadamer (1989) understands hermeneutics as a process of co-creation between the researcher and participant, in which the very production of meaning occurs through a circle of readings, reflective writing and interpretations. Through this process, the search is toward understanding of the experience from particular philosophical perspectives, such as feminist or post-modern positions, as well as the horizons of participants and researcher. Hermeneutic research demands self-reflexivity, an ongoing conversation about the experience while simultaneously living in the moment, actively constructing interpretations of the experience and questioning how those interpretations came about (Laverty, 2003). The use of a reflective journal is one way in which a hermeneutic circle can be engaged, moving back and forth between the parts and the whole of the text (Heidegger, 1993).

This interpretive process continues until a moment in time where one has reached sensible meanings of the experience, free from inner contradictions (Kvale, 1996). However, Laverty (2003) cautiously noted that coming to a place of understanding and meaning is tentative and always changing in the hermeneutic endeavour. It is therefore necessary to account for one’s position and trace one’s movement throughout the research process using a hermeneutic circle.

Consequently, for this study, a hermeneutic phenomenology was selected as research methodology for several reasons. It offered the researcher an opportunity to richly and deeply probe the phenomenon and experiences of being a Muslim in a non-Islamic hospital. Hermeneutic approach enabled the researcher to hold particular positions and understandings about what the researcher knows and thinks about being a Muslim in an acute setting, without having to posit that this prior knowledge was of any great importance. Additionally, it offered an opportunity for the research participants to be genuinely and authentically heard as they expressed their thoughts and ideas about being as a Muslim in Australian hospitals, what it is and what it meant to them.
3.5. Summary

In this chapter the philosophical assumptions underlying the research methodology used in this study were discussed. An outline of phenomenology and its different approaches for exploring lived experience were presented. Phenomenology provides the philosophical framework for this study aimed at describing and understanding the experience of Muslims in a non-Islamic hospital. The methods used in the conduct of this study will be discussed in the next chapter.
CHAPTER FOUR

RESEARCH METHODS

4.0. Introduction

This chapter describes the methods utilised in this study to answer the research question. Although the nature of the research question directs me towards qualitative methods and lends itself to a phenomenology, I was not sure that what type of phenomenology would be correct. I explored the epistemology and ontology of experience and I examined the major work of Husserl (1931/1964), Heidegger (1967/1996), and Gadamer (1989/2000) in order to determine how I should proceed. These works were difficult to grasp and to use practically. I turned to the writing of others to help interpret and critique these works. I have drawn on the work of van Manen (1990/1997) to assist me to deal with phenomenological concerns embodied in this study.

This chapter discusses the research design used in this study and outlines selection criteria for participants. Included is a description of ethical considerations. This is followed by the recruitment strategy. Then the method of data collection and the techniques used for analysis of data are discussed. The chapter presents the strategies that were used for ensuring methodological rigour in this study.
4.1. The Method: Overview

A study method is the steps, which are taken during the research process and offers a systematic way of accomplishing something in an orderly and disciplined manner. Although a range of established methods have been used for phenomenological research, these tend to reflect the philosophical assumption of descriptive phenomenology. For example, the methods developed by van Kaam (1959), Giorgi (1975), and Colaizzi (1978) incorporate the concept of bracketing one’s assumptions and ideas about the phenomenon in question and tend to focus on description, rather than interpretation of the particular study phenomenon. These methods, therefore, are incongruent with the ideas and philosophy of Heidegger and Gadamer which underpin this research.

The discussion in Chapter Three focused on the philosophical underpinning of this research methodology. This Gadamerian phenomenological inquiry was designed to explore the lived experiences of Muslim patients in Australian hospitals. To advance this study and reach an understanding of the phenomenon, it was necessary to choose a method which is congruent with, and reflects the philosophical tenets underpinning the methodology.

Gadamer (1989) believes there can be no method of interpretation. However it would be argued that having no method, Gadamer’s phenomenological hermeneutics is absolutely indifferent. Lacking a clear beginning, a clear absolute principle capable of organising a true philosophy, philosophical hermeneutics cannot attain to its desired result and, consequently, it cannot supply the truth. In addition a lack of any well-defined method in hermeneutic phenomenology does not support a thesis of no method.

van Manen (1990/1997) recognised that many researchers entertaining the thought of conducting hermeneutic phenomenological research might be dissuaded from doing so because of a lack of guidelines. The absence of an appropriate method, or the improper
use of this method, is considered to result in a superficial and false view of reality. van Manen (1990) provides a framework for the research process. He suggests six research activities that a human science researcher must go through in order to uncover meaning. I chose van Manen’s (1990) framework to help me in exploring the experiences of Muslims in a non-Islamic hospital because van Manen’s method reflects the philosophical assumption of Gadamer in a number of ways. It aims to uncover meaning from the life-world, and does not attempt to bracket the researcher’s pre-understanding and assumptions. Moreover the balancing between the whole and the parts reflects the concept of hermeneutic circle explicated by Heidegger (1996) and extended by Gadamer (1989).

The next section describes how I used this framework in carrying out my study.

4.2. The Study Design

van Manen (1990, p. 30) provides phenomenological researchers with a methodical structure for pursuing hermeneutic phenomenological research and suggests that there is a “dynamic interplay among [these] six research activities”. These steps are not meant to be used as a prescribed set of procedures but rather to be seen as suggestions serving to “animate inventiveness and stimulate insight” (van Manen, 1990, p. 30). These six methodical activities are:

1. turning to a phenomenon which seriously interests us and commits us to the world;
2. investigating experience as we live it rather than as we conceptualise it;
3. reflecting on the essential themes which characterise the phenomenon;
4. describing the phenomenon through the art of writing and rewriting;
5. maintaining a strong and orientated pedagogical relation to the phenomenon;
6. balancing the research context by considering parts and whole.

(van Manen, 1990, pp. 30-31)
Although a certain order is implied by the methodological presentation, one can work on various activities intermittently and simultaneously. There is no definite step-by-step linear research procedure to follow. The following sections will describe each step in more detail.

4.2.1. Turning to the phenomenon

van Manen (1990) describes the first activity as one of turning toward the phenomenon. “It is always a project of someone: a real person, who, in the context of particular individual, social, and historical life circumstances, sets out to make sense of a certain aspect of human existence” (van Manen, 1990, p.31).

The starting point of my research journey to explore the meaning of being a Muslim patient was when I came to Australia to study. On reading the professional literature I became aware of the lack of studies on Muslim patients’ experiences in a non-Islamic hospital. As a nurse and a Muslim person, I became interested in how Muslim patients experience hospitalisation in a non-Islamic hospital.

This first step involved the formulation of the research question. The phenomenological question, according to van Manen (1997), is only possible when one has identified an interest in the nature of human experience. Consequently, my desire to bring to the forefront the experience of being a Muslim patient, as a phenomenon that human beings live through, directed the research question: ‘What is the lived experience of being a Muslim patient in a non-Islamic hospital?’

Beyond this initial turning to the phenomenon, it was the aim of the study to dig deeper and to find the essence of meaning that is within the lived experience of Muslims. Chapter One of this thesis described the background of this research and outlined the phenomenon of interest.


4.2.2. **Investigating experience in the participants’ world**

The source of phenomenological research is the life world. In order to understand the phenomenon, it was necessary that I entered the lives of those people who had lived through the experience. van Manen (1990, p. 69) suggests that “the best way to enter a person’s life world is to participate in it”. Therefore, I went to the source of the phenomenon and interviewed Muslim people who had been hospitalised in a non-Islamic hospital to ascertain how they experienced their hospitalisation.

I conducted unstructured interviews with participants to seek their experiences as a Muslim person by asking them to talk about their experience of being admitted as a patient to an Australian hospital. Listening to their stories enabled me to reflect on how their religious affiliation affects their lived experience during hospitalisation. I constructed open-ended questions that aimed to elicit descriptions from the participants and to allow them to tell their story of hospitalisation (Koch, 1995a).

My initial impression after the first few interviews was of concern as I was worried about the flow of the interview and that the interviews may not uncover the richness of data I was seeking, however, as the number of interviews progressed I found that I became immersed in their stories and that the participants words provided the depth of understanding I was seeking. These initial descriptions provided the foundation and basis for reflection and analysis, and the later development of the essential themes.

4.2.3. **Reflecting on the essential themes**

The true reflection on an experience is “a thoughtful reflective grasping of what it is that renders this or that particular experience its special significance” (van Manen, 1990, p. 33). When conducting phenomenological research, finding a way to articulate the essence of the participants’ experience is crucial to the overall interpretation of the phenomena. Finding those participants’ words that capture the essence of their story requires a deep reflection on the language of the text. This involved a process of careful
and detailed reading and rereading of all the participants’ text in order to make the essential structure of their descriptions explicit.

The process of identifying the essential structure of their stories was not precise. It required sensitivity and openness for appreciating what might be revealed. I recognised the importance of reflecting on themes that emerged from the interview transcripts. As van Manen (1990) suggests I used three approaches to recognise significant structures. Using the wholistic approach, I asked, “What sententious phrase may capture the fundamental meaning or main significance of the text as a whole?” (p. 93). When applying the selective reading approach, I listened to the audiotapes and read the interview transcripts several times to ask, “What statement(s) or phrase(s) seem particularly essential or revealing about the phenomenon or experience being described?” (p. 93). Finally, in using a detailed reading approach, I looked at every sentence or sentence cluster to ask, “What does this sentence or sentence cluster reveal about the phenomenon of experience being described?” (p. 93). This essentially reductionalist approach facilitated the development of essential structures which formed the beginnings of interpretation and understanding.

4.2.4. Hermeneutic phenomenological writing and rewriting

Creating a phenomenological text is the object of the phenomenological research process. van Manen (1990, p. 7) reminds us “hermeneutic, phenomenological research is fundamentally a writing activity”. He stresses the importance of writing in human science research and pointed out that:

…for hermeneutic phenomenological work, writing is closely fused into the research activity and reflection itself…. Writing fixes thought on paper. It externalises what in some sense is internal; it distances us from our immediate lived involvements with the things of our world... Thus, writing creates the reflective cognitive stance that generally characterizes the theoretic attitude in the social sciences. The object of human science research is essentially a linguistic project: to make some aspect of our lived world, of our lived experience, reflectively understandable and intelligible… to write is to measure the depth of things, as well to come to a sense of one’s own depth (van Manen, 1990, pp. 125-127).
The writing process helped me to be closer to the experience of being a Muslim patient in a non-Islamic hospital through writing about the participants’ experiences, as well as reflecting on my own. In order to write about the experience of Muslim patients in an Australian hospital, I had to bring understanding and interpretation together in a common language, a common frame of reference. I intended to make visible to the reader the feelings, attitudes, and thoughts of the participants. Through the writing of Chapter Six of this thesis, the themes that evolved will make visible the participants’ experiences.

4.2.5. Maintain a strong and oriented relation

It is very common for researchers to lose themselves in the activity of investigating the phenomena. When this happens, the primary focus or question that stimulated the research can become blurry. I needed to maintain my sense and beliefs about being a Muslim patient in order to see clearly the Muslims’ experience in an Australian hospital.

I was extremely careful to remain sensitive to the question: ‘What is like to be a Muslim patient?’ In the later stages of the study when the themes seemed to provide some insight, I worked again through each transcript to examine whether the data supported the emerging interpretation. My desire was to produce texts, which present textual themes in concert with the notion of the phenomenon.

It was my principal desire that those who read my text would be able to connect with it as a legitimate experience. The text should be read as one that encompasses not only the experience of Muslim patients, but also the way in which it influences how a person related to the world. Consequently, throughout my research, I remained open to the potential to explore alternative ways of caring for Muslim patients.
4.2.6. **Balancing the research context**

The activity of balancing the research by considering parts and the whole is closely related to reflecting on essential themes and maintaining an oriented relation to the subject of the research project (van Manen, 1990/1997). It was sometimes necessary to take a step back for a look at the whole picture of the experience, considering the parts and the whole, in order to understand how each participant’s story contributes towards developing the whole picture of being a Muslim patient in a non-Islamic hospital. I needed to look at the end and the beginning, the past and the future to determine essential and interconnected structures. The researcher constantly scrutinises the phenomenon under investigation by moving between the parts of it and the whole picture. This step matches the hermeneutic circle that Gadamer introduced (Annells, 1996). Throughout the process of interpretation, I was fully immersed in the hermeneutic circle.

After I had a number of text, I proceeded to use a circular process involving continual dialogue between seemingly meaningful words, phrases and concepts, and questioning these sections of the text to ask ‘what is really being said here?’ is part of the analysis process. Initially, this involves the individual text (that is the participant’s stories). Once emerging words and concepts develop from these individual parts they were then reviewed and questioned in light of the whole perspective and questions such as ‘Is this concept shared or different from other perspectives?’ ‘What does this mean in relation to the phenomena?’ were asked. One must remember such things as: ‘Is the study grounded in a proper examination of the question?’.

4.3. **The Study Participants**

Hermeneutic phenomenological studies, like other qualitative studies, involve two sets of people: those who do the research and those who provide the information. The people cooperating in a study play an active rather than a passive role in the research, and are
usually referred to as study participants. Therefore the study participants were people who participated and provided information in this research.

**4.3.1. Inclusion**

The participants were selected based on their particular knowledge of the phenomenon. This study focused on exploring and understanding the meaning of being a Muslim in an Australian hospital. In order to achieve this intention, I needed to turn to people that were representative of the experience in question. Therefore the first criterion for inclusion in the study was Muslim people who had been admitted in an Australian hospital for a healthcare related issue.

To be part of the study, the participants needed to have been hospitalised at least on one occasion. It was also desirable that participants had experienced this episode of healthcare within two years, as a longer period of time may have made their ability to recall the experience more difficult. Also a minimum length of stay of at least three days was desirable, as it was judged that this time period was sufficiently long enough for participants to formulate perceptions about hospitalisation.

Finally, due to resource limitations and time restraints only Muslim people who resided within South Australia were targeted for recruitment, as this was where the researcher was based and would practically facilitate the conduct interviews.

All participants were required to be adults (greater than 18 years of age) who were willing to volunteer to be involved in the study by giving their written informed consent.

**4.3.2. Exclusion criteria**

Participants were only excluded if the reason they were admitted to an Australian healthcare facility had resulted in them being unconscious, mentally incapacitated or
neurologically impaired, as these conditions would impair their ability to recall the hospital experience.

When developing inclusion and exclusion criteria for this study, an issue pertaining to the inclusion of genders arose. Although there is generally no disparity between Muslim women and men in respect to their religious affiliation there does exist within Islamic principles some difference between genders, such as those surrounding the expectations of women to maintain a Hijab dress (as outlined in chapter one) and the interaction between female and male Muslims. Initially, I considered excluding female participants from the study based on an assumption formulated from their own personal experience of interacting with unfamiliar Muslim women, in that they may not be willing to share their experiences and perceptions of hospitalisation with a male researcher. It was assumed that these experiences may be of a personal nature and that the female participants may not feel comfortable about expressing these feelings with a male researcher. I had considerable discussion about this issue with my supervisors (one being a female person), and consideration was given to the use of a female assistant to conduct the interview or having a family member present during the interview. However, these strategies were dismissed as the researcher wanted to assure that all interviews were conducted in a consistent manner.

In addition, it was acknowledged that excluding women from this study may have excluded the researcher from identifying potentially important and insightful experiences of hospitalisation that may only have pertained to female Muslims. Consequently a final decision to target both female and male Muslim participants during the recruitment process was made. This would give those women approached to be involved in the study the right to make a decision about whether to participate or not, knowing that they would be asked to share their personal experiences and feelings and that the researcher conducting the interview was a male person.
4.4. Recruitment

Recruitment refers to the processes employed by the researcher in order to identify and attract individuals that meet appropriate selection criteria to participate in research (Butterfield et al., 2003; Miller, McKeever, and Coyte, 2003; Steinke, 2004). Recruitment is a fundamental component of the research process and the approach taken will depend on the nature of the study. The importance of the planning phase for recruitment cannot be understated.

Before beginning the recruitment process, it was critical to identify the number of Muslims who lived in South Australia and the accessibility of Islamic centres and community-based institutions to gauge the diversity and number of the potential population from which recruitment would be targeted. The Internet, Chaplaincy service, local Migration Resource Centre and Islamic Women’s Association proved valuable in this step.

It was anticipated that recruitment would be difficult not only due to geographical accessibility, but also that participants may be culturally resistant to participating in the research. For these reasons, several recruitment strategies were employed to help reach the target number of participants and included: hospital-based recruitment; snowball sampling; advertising; and contact with key people.

4.4.1. Hospital-based Recruitment

One pool for recruitment of potential participants was a large tertiary metropolitan hospital located in South Australia. In order to identify and recruit Muslim inpatients from this institution, it was first necessary to gain the support of Clinical Nurse Consultants (CNC) of the hospital. These are the nurses in charge of clinical management of wards. Once the researcher had met with and provided written information (Appendix 1) to the CNC’s about the study they agreed to assist in the identification of Muslim patients. Their involvement consisted only of giving information sheets (see appendices 2 and 3) which explained the purpose and nature of
the proposed research to potential participants, and if people were interested passed on this information directly to the researcher. The researcher then made contact with those people while in hospital. Muslim patients were only identified in the hospital setting for possible involvement but were not formally interviewed at that time.

The researcher made regular contact with the CNCs during the recruitment phase of the study and distributed written flyers about the study to all wards throughout the hospital.

In addition, identification and recruitment of Muslim patients within this hospital were achieved with the aid of the hospital’s Chaplaincy Service. The Chaplaincy Service of this institution assisted in identifying Muslim inpatients as they received a daily list of patients admitted to the hospital. This list provided the Chaplain Service with admission details indicating each patient’s nominated religion. I contacted the hospital chaplain who dealt with Muslim patients over that period to discuss the study with them and ascertain whether they may assist in the recruitment of potential participants. They agreed to inform me when potential Muslim patients were admitted to hospital.

Those patients identified by either the Chaplaincy Service or the Clinical Nurse Consultants were given a copy of the participant information sheet and if they expressed an interest in this study were approached by the researcher, who answer any questions and obtained their written consent to participate. Once discharged from hospital they were again contacted by the researcher to arrange a suitable time for the interview.

### 4.4.2. Snowball Sampling

Snowball sampling relies on participants successfully recruited to name other potential people that may be interested in being involved in the study. The use of snowball sampling is particularly useful when the target population is dispersed and they are known within a personal network (Denzin and Lincoln, 2005; Petersen and Valdez, 2005). Snowball methods take advantage of the social networks of identified respondents to provide the researcher with an ever-expanding set of potential participants, allowing a series of referrals to be made within a circle of acquaintance.
Snowballing is particularly applicable where the focus of the study is on a sensitive issue (Browne, 2005; Steeton, Cooke, and Campbell, 2004). The participants were asked to name acquaintances, friends and relatives whom they felt might be eligible and interested in participating in the study. Then I contacted those people identified in this way and provided them with information about the study.

### 4.4.3. Advertising

Another strategy to recruit participants was through advertising. Advertising is one of the most common promotional strategies to inform people about a study. Media used to promote research may include television, radio, newspapers, magazines, posters and fliers. However, there are factors that have to be taken into consideration before deciding which form of media is to be used for advertising the study. These factors include selectivity, coverage, and cost of advertising. Selectivity refers to the availability of the medium to reach the required audience, participants. Coverage refers to the number of the potential participants that the medium can reach. Cost is an important factor and refers to the amount of money that the researcher has to fund to place the advertisement and the researcher has to evaluate whether it is worth it for the participants that he will be reaching (White, 2006).

I utilised a text form of advertising in this study. A poster advertising the study was displayed in various Muslims community services. Advertisements outlining the details of the study were placed in local community newspapers and newsletters, and on notice boards at mosques and Islamic centres (see Appendices 4 and 5). Eligible people who were interested in becoming involved in the study were asked to contact the researcher.

An unanticipated issue that proved challenging was the choice of language in which the materials related to the study were written. Being a Muslim from an Islamic community I was aware of the difficulties with language and that Muslims speak more than 60 different languages (Behrouznia, 2001). Farsi is one of the common languages spoken by many Muslims and was familiar to the researcher. Consequently, both English and Farsi versions of recruitment materials were provided and distributed in places where
Farsi speaking people were expected to predominate. Several advertising strategies were employed in order to attract Muslims into the study. Advertising proved to be more time consuming and expensive than anticipated with frequent re-printing of materials and travel associated with renewing posters and flyers. This became frustrating, particularly when advertising did not prove successful in recruiting any Muslim people into the study.

### 4.4.4. Contact with Key People

In hindsight, contact with key Islamic people, such as Muslim health professionals, priests of mosques and administrators of Islamic communities, proved most useful in providing access to potential participants and was central to the success of recruitment. The challenge in using this strategy was to ensure the appropriate people were approached for assistance in recruitment and to ensure that frequent contact was made with key individuals in order to establish good rapport and to ensure they were willing to offer some assistance. During this phase, clear procedures for recruitment were established as potential participants needed to know exactly what they were asked to do, how much time they were expected to give, and what use would be made of the information they provided to the researcher. Gaining trust and commitment was essential as the success of this strategy was dependent on the relationship established with key networks at this preliminary stage. I also needed to ensure an appropriate balance was established between allowing sufficient time at meetings to allow key contacts to understand the nature and intention of the research, and taking too much time so that key contacts felt imposed upon.

After meeting with these people they were given an information letter (Appendix 1) describing the research, the purpose of the study, and the criteria of possible participants for selection into the study. If they agreed to act as a facilitator and promote the study at appropriate venues and meetings they were provided with copies of the participant information sheets outlining the purpose and nature of the research (see Appendices 2 and 3).
Once the name and contact details of potential participants were obtained through key personnel, I made telephone contact with them and screened each person to determine whether they met the inclusion criteria for participation prior to arranging the interview.

### 4.4.5. The Recruited Participants

As previously described, when the contact details of the participants were obtained through one of the above recruitment strategies, the first contact with the study participants was made by telephone or by face-to-face visit in the hospital prior to their discharge in order to discuss the details of the study, their level of involvement and answer any potential questions that they had. I also explained the need to audiotape the interview so that I had an exact recording of their experience that would assist me in analysis of data.

Overall participants were difficult to recruit into this study with only thirteen successfully enrolled over a 12-month period. Trust was the central issue here. My experience with Muslims suggests they can be fearful of strangers and many were uncertain about being involved. Those who did agree to participate were motivated by their friends who named them, as they could be reassured about their level of involvement by someone they knew and trusted.

The participants were mainly recruited through hospital recruitment, snowball sampling and contact with key people. Seven of the participants were recruited using snowball sampling with two others recruited through contact with key people. A further four participants were recruited through the Chaplaincy Service and nurses at the hospital. Although it was anticipated that advertising would be a useful strategy to recruit people for the study, no participant was recruited in this manner.
4.5. Participants numbers

For this study, a target of twenty participants for recruitment was set, as it was anticipated that this number would provide enough data to gain a sufficient understanding of the meaning of being a Muslim patient in a non-Islamic hospital. However, this target number was purely ambiguous and proved difficult to reach, despite multiple recruitment strategies being employed. The number of participants in interpretive research is typically small as large volumes of data may be generated (Morse, 1995). Therefore to guide the researcher in determining the appropriate number of participants to recruit for this study a technique known as ‘saturation’ was employed. (Morse, 1995, p.142) defines saturation as “data adequacy” and is reached when “no new information is obtained”. She explains that no published guidelines exist for estimating the sample size required to reach saturation and that although data may initially appear diverse and disconnected, through a process of data saturation, patterns and themes begin to emerge and make sense (Morse, 1995). It is not possible to estimate prior to data collection the amount of data required to create these patterns and themes.

It became evident during the process of data collection that after interviewing thirteen participants, sufficiently rich data had been collected to provide an in-depth understanding of the phenomenon. In addition, it was possible for the researcher to manage the data for this number of participants. It was felt that the sample number of participants, although small, was congruent with phenomenological studies. The number of participants in interpretive research is typically small as large volumes of data may be generated (Marcus and Liehr, 1998; Morse, 1995). Consequently the final sample number for this study was thirteen. It should be noted again that this number of participants was not the target for the study.
4.6. Ethical Consideration

Recruitment and subsequent data collection did not occur until after formal institutional Ethics Committee approval has been obtained (see Appendix 6) The National Health and Medical Research Council (NH&MRC) points out that:

When conducting research involving humans, the guiding ethical principle for researchers is respect for persons which is expressed as regard for the welfare, rights, beliefs, perceptions, customs and cultural heritage, both individual and collective, of persons involved in research (National Health and Medical Research Council, 1999, p. 11).

When research involves or touches on potentially sensitive issues such as ethnicity, religion, and issues involving minority groups, there is an increased need for the researchers to carefully consider potential participants’ rights and ensure that sound ethical principles underpin the study. Denzin and Lincoln (2002) state all research studies which involving human participants need ethical approval prior to commencing the research in order to make sure that participants’ dignity and privacy are protected and to minimise any potential risk to participants. This may be particularly important when research involves a minority religious population such as in this case, Islamic people. Therefore I endeavoured to remain cognisant of the principles which ensure the participants’ welfare and rights are protected throughout the duration of the study (National Health and Medical Research Council, 1999).

Throughout the duration of the study, the following ethical principles were applied: informing participants of their rights and level of involvement in the conduct of the study; their ability to withdraw from the study without penalty; issues of privacy and data confidentiality; and attainment of informed consent.

4.6.1. Participant Information

During recruitment, any potential participants were given information that provided a detailed explanation of the study and its procedures prior to obtaining informed consent. The information sheet (see Appendices 2 and 3) informed participants that they would
not be identifiable from the research, informed them of the nature and purpose of the study, and provided the name and telephone numbers of the chief researcher, Chairman of the Ethics Committee and the student’s supervisors in case further information or feedback was required.

It was important that I was sure that potential participants fully understood the content of information sheet. As in some cases it was possible that English language was not the primary language spoken and understood by all Muslim people living in South Australia, a translated version was developed and made available when appropriate. Through my own experience, I became aware that Farsi language was found to be most commonly spoken in addition to English by many Muslims in South Australia, and as this was also familiar to me, a Farsi language version was offered to potential participants where appropriate (see Appendix 3). This step gave me some confidence that potential participants were fully informed about the nature of the research and were in a position to make a fully informed decision as to whether or not to participate in the study.

After giving them the information sheet I made myself available to answer any questions and to clarify any issues that the participant had in respect to the study and their involvement. In addition, I assured potential participants that they had a right to withdraw from the study at any stage without prejudice to their medical and/or nursing care at that time or in the future.

4.6.2. Privacy

The NH&MRC states that “privacy is a complex concept that stems from a core idea that individuals have a sphere of life from which they should be able to exclude any intrusion” (National Health and Medical Research Council, 1999, p. 52). In order to maintain the privacy of an individual involved in this research, I endeavoured to maintain the confidentiality of the participants. I assured those patients willing to participate in the study that defining information relating to themselves, another person or any institution uncovered during the course of this study would be deleted from the
transcripts or changed to ensure anonymity. Anonymity of individual participants was assured by allocating fictitious names to all participants and any specific information that could potentially identify any participants deleted from transcripts and computer files.

### 4.6.3. Consent

Once potential participants had read the information sheet and the researcher had answered any questions related to the study, participants were asked to indicate their willingness to be involved in the research. If they agreed they were then asked to sign a consent form (see Appendix 7) indicating their willingness to participate in this research study and that the nature and purpose of the study had been explained to them. Written informed consent to take part in the study was obtained from each participant before the interview was conducted. Once again, a version translated into the Farsi language was made available to any participants as required (see Appendix 8). The consent form detailed the following: the participants’ willingness to participate in the study for no money; that they were informed about the nature and purpose of study; that they had the right to withdraw from the study before, during or after their participation without any consequence; that they were assured that the researcher understood the need for participant confidentiality and anonymity; and that they were able to talk about the study with someone not directly involved such as the chairperson of the Research Ethics Committee, if they so desired. The name and telephone number of the chairperson and the researcher was provided in case more information or feedback was required.

By signing the consent form the participants indicated that they understood the nature of their participation and voluntarily agreed to participate. While voluntary participation is considered a universal mandate for research involving human beings, the participants’ freedom of choice about participation was realised as the most comprehensive means of addressing the emotional risks of their involvement. Their freedom of choice to participate and withdraw, at anytime, from the study was determined to be the primary way that the participants could maintain agency over what they felt capable of contributing to the study.
4.6.4. Specific Considerations

Asking questions related to religion and belief systems can be very sensitive to some individuals. The centrality of religion to Muslims meant that religion would very likely be an important issue raised in exploring their experience and so great caution was required. Muslims are a minority population in Australia and in the current socio-political climate may be very sensitive to examination from a researcher. As with any marginalised population there is a need for specific strategies to ensure methods are ethically appropriate. Certainly the fact that the researcher was Muslim assisted in this area.

The highly personal content of the study could present some challenges to the participants that required careful consideration of their ethical rights. The research included discussions on issues that may be sensitive for participants to answer. Sensitive discussions might include those dealing with religious practices as a Muslim, for example drinking alcohol or eating non-halal foods. Every effort was made to ensure that the participants involved were not put at the risk of distrust from shared information and I gave each participant the option to not share any information she/he was unconformable with, thereby reducing any feelings of threat or risk to the participants. Therefore, before conducting formal audio-taped interviews, it was important to be developed a good rapport with each participant.

It was vital that women participants were encouraged and supported. While Muslim men and Muslim women are often considered together because of the same interest of their religion, they may experience more stress in their involvement within the research study because of gender. Therefore all women participants were encouraged to have one of the family members during the interview to ensure adequate support and to promote effective interaction between the participant and researcher.
4.6.5. Data Storage

The NH&MRC (National Health and Medical Research Council, 1995) recommends that the data should be kept for a minimum period of five years from the completion of the research and then destroyed. During the study period the taped interviews, transcribed texts and consent forms were stored in a locked cabinet in the researcher’s office. On completion of the study, all identifying details, audiotapes, transcripts and consent forms will be kept in a locked cabinet for at least five years.

After each interview was conducted the researcher transcribed the audio-taped conversations into a Word Processor and each document was saved onto a computer disk. All computer files were password-protected to prevent others from accessing confidential data.

4.7. Data Generation (Interviews)

Interviews have become a common feature of data collection in qualitative research and according to Robinson (2000), have become a mainstay of qualitative nursing research. Interviews provide participants with the opportunity to fully explain the experience of the phenomena of interest. Phenomenological interviewing requires open dialogue and questions which maintain a focus on experience (Koch, 1995b), thus little structure was applied by the researcher.

I used a single, in-depth, open-ended interview approach to collect data in this study, which involved unstructured questions. Using unstructured questions provided the opportunity for me to engage with the participants and encourage fluency and rich disclosure. It was important to allow participants to tell their story in the way they chose themselves.

The location for the interviews was at the discretion of each participant. All except two interviews were conducted in the participants’ own homes. One person was interviewed.
at their workplace and another in the researcher’s office. All participants were informed that they could bring a close family member or friend with them to the interview, if they desired. In addition, the participant Consent Form (Appendices 7 and 8) was discussed and completed with each participant prior to commencing the interviews.

The audio taped interview with each participant began with an informal talk. The purpose of this informal chat was to establish rapport with the participants and to build trust and allow them to be comfortable with the researcher and the research process. Rapport between the researcher and participant was fundamental, not only for the data collection stage, but also for the study overall. If good rapport is absent then the descriptions will lack depth and accuracy and the final product of the study will be neither valid nor reliable (Osborne, 1990).

At the beginning of each interview the researcher requested that participants talk briefly about their life. The question posed was: ‘Please tell me about your life as a Muslim person?’ From there, I followed the flow of content as meanings and events of interest, religious beliefs and practices, were disclosed. I used it as a neutral topic of conversation to built rapport with the participants. As well, this starting question identified the background to the current life situation of each participant. Heidegger (1993) considered that individuals are embedded in a world where they have a past, present, and future, all of which influence the current situation. Thus, to reach an understanding of the meaning each participant attributed to their lived experience of the phenomenon, required that I have some understating of each participants’ background.

I then asked each participant to recall their experience of the phenomenon - being admitted to a non-Islamic hospital as a patient. As the interview was unstructured, there was no formal protocol to follow with specific questions asked. However in some of cases certain specific questions were required to keep the interview focused on the phenomena and to gain the depth of description that was sought. Examples of these questions were:

- Tell me about the reason why you were admitted to hospital?
- Outline for me what the issues were that led up to your hospitalisation?
• Please describe in detail your experience of being a patient in non-Islamic hospital, including the events that occurred and how you felt about being a Muslim in a non-Islamic hospital?

The first two questions were contextual in that the intent was to elucidate from each participant the reason and circumstances surrounding their admission to hospital. This information would provide data that would be unique to each participant and be useful in the first stage of data analysis, that being to describe each participant and their relationship to the phenomena.

The later questions focused on the phenomena of hospitalization and sought to encourage participants to describe the event in detail, expressing their recalled feelings, emotions and attitudes toward the experience of being a Muslim person admitted to a non-Islamic hospital. The intention here was not to constrain the participants or overly influence their responses but was used only as a mechanism to encourage them to explore their experience.

During the interview if participants touched on religious or cultural issues that were of obvious concern to them, I encouraged them to talk about these issues in more depth, trying to ascertain how these issues affected them. Examples of these questions were: ‘I notice, one of things you said was important for you and you liked to do while in the hospital was praying. How did you go about this?’ and ‘You stated that according to your religious practice, you eat just halal foods and the foods which were provided in the hospital were not halal. How did this make you feel?’

I was aware that some participants might be reluctant to share these personal thoughts and emotions or find it difficult to talk freely about their experience as a Muslim person. A number of strategies were used to assist participants with this reluctance. In particular two strategies were found to be useful. I allowed each participant plenty of time to express themselves and did no push them into talking about things they did not find comfortable. I tried throughout to be encouraging, patient and supportive. The second strategy was to conduct the interview in the language most comfortable for participants that is either in English or Farsi. This was only possible as I am fluent in Farsi.
Towards to end of every interview, I afforded each participant the opportunity to add anything to our discussion by asking the following question: ‘Is there anything else would you like to add in relation to your experience that you feel is relevant?’ After this the interview was concluded.

The duration of the interviews ranged from 40 minutes to 65 minutes, with an average duration of 48 minutes. The interviewing process started in August 2004 and terminated in October 2005.

I was cognisant of the possibility of the participants experiencing emotional reactions after telling their stories and so, when invited for tea, I spent at least one hour with them following the audio-taped sessions. This was an extremely important part of the process as it allowed us to talk without the formality of audio-taped interview. Although the information obtained from the informal discussion has not been included as data, it was used to assist me to building rapport and contextualising each participant.

Each interview was transcribed verbatim onto a word processor as soon as possible after each interview to allow data analysis to be conducted on the written transcripts. Following verbatim transcription, the transcripts were proof read while listening to the tapes to check accuracy prior to analysis. I returned to the tapes on numerous occasions during the transcription process to assure accuracy. For those interviews that were conducted in Farsi language, they were translated into English as a written text. Each participant’s transcript was labelled and managed as a separate document and I removed any identification detail related to the participants. For example, the transcript of the first interview with Fariba was labelled ‘TFA1.doc’.

The following extract is taken from the sixth interview with Shakira (TSH1.doc).

Interview no: 6
Participant name: …..
Pseudonym: Shakira
Date: 07.10.2004
Time: 6.30 – 7.30
Venue: Living room in participant’s place in presence of her husband
Cassette no: 6-SH, sides A and B

NOOR: Thank you for participating in this study. To start, Tell me about the reason why you were admitted to hospital?
SHAK: I was hospitalised for four times. All the four times have been for complication of pregnancy and childbirth. However, all of my admissions were not succeed to keep my child safe and I lost my child [Shakira pauses and looked at her husband]. Well, you know this event has greatly affected my opinion of the services in that particular hospital by that particular team who attend to my delivery. I feel very painful whenever I back to the time which I was in the hospital.
NOOR: How did you feel about the event that occurred?
SHAK: When I was in the hospital, I had been psychologically stressed with a strong feeling of homesick which compounds the stress. Having a family member, relations, elderly around, and not being in a strange culture is very important, particularly in the case of life threatening conditions that patient need been hospitalised in an acute setting. I lost my child. I have a feeling, only a feeling which is not based on any facts or evidence, that if I were an Australian, my child would be safe and have lived. I cannot and don’t find any specific snail fall or disservice by any particular person. I think the whole team failed in saving my child. I feel that they did not take my signals of danger and did not pay appropriately attention to the symptoms and signs. Even they did not care to my cries for help seriously. I had over trusted the hospital and medical staffs. I had also relied on my ability to communicate with them both verbal language as well as body language. But it seems that at the critical and vital time, they did not understand me, the communication broke.
NOOR: have you ever found them to be helpful?
SHAK: They had offered an interpreter while I had not needed one. In fact, the problem was not language and verbal communication. If this delivery had happened in my homeland, I am sure the more experienced relatives around me the have helped me. They would have picked up clues from my gestures about the severity of my situation. The service delivered in the hospital was good, but could not save my child. I had trusted them fully. I should have left same scope for risks and dangers. I think, I had to receive the same services as other people receive regardless my beliefs and values.

NOOR: let’s think about other aspects of your hospitalisation. Please describe in detail your experience of being a patient in non-Islamic hospital.
SHAK: The first reaction as a Muslim woman receives from non-Muslims is an indicator of that person’s preconceived opinions and feelings. However in the hospital even if individual staff had different feelings, opinions and reactions, this did not affect them in practice and performance of their duties at all. Their individual feelings and opinions are kept separate from their obligation to duty. Medical staffs must respect to patient’s beliefs and
values. You know, as a Muslim I had specific needs when I was in the hospital.

NOOR: Let’s get to know your specific needs as a Muslim here? Would you explain more about your specific needs?

SHAK: In my eyes, Muslims have to receive proper halal food when they are in the hospital. Patients had many choices in the list. But there were few choices for me. If I liked to eat meat, I had to arrange it by my family. I would prefer look after by same gender medical staffs.

NOOR: And the problem with that...?

SHAK: I think, same gender doctors and nurses are preferred by all religions especially when it comes to childbirth. When they had same gender doctors and nurses, they did provide them when they did not they apologised. Although I had not good feeling when a male doctor was visiting me, it was not very bothering issue because I had realised my situation. But when I shared rooms, male visitors of other patients bothered me. Privacy is something that nurses have to be vigilant on. But it is extremely trick for patients from an Islamic background. My feeling about privacy is that you tell people what you expect to do and what you do not expect to do.

NOOR: Okay, good. Is there anything else would you like to add in relation to your experience that you feel is relevant?

SHAK: I can’t remember something anything else for now. Thank you so much.

NOOR: I appreciate that your cooperation and attending in this interview.

I also made notes in a fieldwork journal about each participant throughout the whole data generation process. The notes I took contained demographic information, and tried to capture any information gained throughout the informal discussions, also taking note of body language, expression and tone of voice for each participant where appropriate. Notes about each participant were labelled to match the names and interview labels assigned to each participant’s transcript, for example, NHA1.doc. The following note is taken from my journal note.

When I first arrived at Habib’s property, I found myself knocking on the wrong door. His neighbour pointed to a dark brick building, further down the road. The driveway was lined with trees, all bearing fruit. I recognised them as lemon trees. Habib’s wife stood near the front door to welcome me. She stopped me from taking my shoes off ‘don’t do that’ and then proceeded to say ‘but you can if you want’. After a quick glance at her bare feet, I decided to leave them off. Habib, a 38-year-old man, was sitting close to the television. His voice was soft, something I had already noticed when we
spoke on the phone. My first impression of Habib was that he was an intelligent man. He invited me to sit on a kitchen chair next to him. He had a bit of a smile when I explained that I had mistakenly knocked on his neighbour’s door. After briefly explaining the study again, he said that he had no questions. I turned the tape recorder on, with the volume knob turned up on maximum level.

4.8. Data Analysis Process

Once the information was gathered, I was faced with the decision on how to analyse the participants’ stories. The process of data analysis was through a combination of Gadamer’s notion of fusion of horizons and van Manen’s reading approaches for thematic analysis that I arrived at an understanding of the phenomena of being a Muslim patient.

By using an interpretive approach, I undertook the task of transposing my insight into a textual form that describes the phenomenon of Being a Muslim in non-Islamic hospital. I used significant concepts from Gadamer (1989) that were embraced throughout the data analysis process were notions of the hermeneutic circle of understanding, prejudice, linguisticality of understanding, fusion of horizons and lived experience.

Within this research, prejudices are expectations or projections about the whole that are continually revised as more parts of the whole come into view. Gadamer asserts that understanding involves discriminating among prejudices, not eliminating them; questioning our beliefs about our understanding and becoming prepared for it to say something new; and responding with an openness to the unexpected (Gadamer, 1989). Therefore, in this study, making use of prejudices, continually asking questions or dialoguing with the text, and sorting out the text was the process of interpretation itself. For this study, fusion of horizons occurred on multiple occasions, as a cyclic activity, as the phenomenon of being a Muslim in a non-Islamic hospital was identified, not only within each participant’s story but also across their stories.
In addition, as an important part of this research was to obtain the essential features of participants’ experience, I was aware that the best way to achieve this was to conduct a thematic analysis in order to extract consistent themes as they emerged. Thematic analysis is a qualitative data analysis technique designed to extract consistent themes and patterns from a wide range of written or verbal communication (Williamson et al., 1982). Although thematic analysis has been frequently described in literature (Turner, 2003), there is insufficient information that outlines the pragmatic process of thematic analysis.

In the process of data analysis, I read all transcriptions several times to list the patterns of experience of Being a Muslim patient which emerged from the participants’ stories. Furthermore several of van Manen’s techniques for analysis, such as the wholistic, selective and detailed reading approaches, were used to isolate significant statements and concepts from each of the participants.

I have used a “selective or highlighting approach” (Seamon, 2000, p. 94) to obtain a phenomenological textual interpretation. This provided the opportunity to examine each interview carefully and to identify textual sentences or phrases that could be thematic of the experience. Verbatim excerpts from texts are used throughout to illustrate themes and support chosen interpretations. Selection of quotes was difficult because choosing what to include had the potential to omit other equally cogent quotes.

The next step was to identify all data that relate to the already classified patterns. Then I combined and catalogued related patterns into sub-themes and themes. Themes were pieced together to form a comprehensive view of the phenomenon of Being a Muslim patient. Then I built a valid argument for emerging themes. I tried to strike a balance and ensure that each voice was heard at various points. The process of thematic analysis will be discussed in detail the Chapter Six.
4.9. Rigour

When using qualitative research methodologies, the question of rigour arises. Rigour refers to the issues that are raised by the terms ‘validity’ and ‘reliability’. Validity can be defined as “a concern with the questions: Does the instrument or measurement strategy actually measure what the evaluator proposed to measure” (Crowell, 2002, p.30). Reliability refers to “the consistency or dependability of the instrument or measurement strategy” (Goodwin and Goodwin, 1984). Qualitative researchers use the term ‘rigour’ to indicate that the concepts of validity and reliability are important in qualitative research, but that they “need to be conceptualised differently” (Crowell, 2002, p.31).

Rigour in phenomenological nursing research is a controversial topic (Barkway, 2001; Koch, 1995b) and an important issue with direct implications for the legitimacy of the body of knowledge that defines and informs nursing practice, publication, and funding of research studies (Koch, 1998). The need for qualitative criteria of rigour emerged in the early 1980s during the stormy debate surrounding the legitimacy of qualitative vs. quantitative research in the disciplines of anthropology, sociology and education (Emden and Sandelowski, 1998). However criteria of rigour specific to interpretive research studies is problematic because the prominence of philosophy in the methodology and method of interpretive phenomenology amplifies the risk of inconsistencies with philosophies that inform other qualitative methodologies or the very criteria that are used to evaluate rigour.

Qualitative criteria of rigour are necessary to ensure systematic, accountable, and high quality research methodology (Morse et al., 2002). The following strategies used for ensuring methodological rigour in this study:

Participants for this study were chosen as need and recruitment continued until data provided a thick, rich description of the study phenomenon and no new themes or patterns emerged (Glaser, 1992). According to Denzin (2001, p. 162), ‘thick description’:
…does more than record what a person is doing. It goes beyond mere fact and surface appearances. It presents context, emotion and the webs of social relationships that join persons to one another. Thick description evokes emotionality and self-feelings. It inserts history into experience… In thick description, the voices, feelings, actions, and meanings of interacting individuals are heard.

A thick, rich description provides a deep, dense detailed account of an experience. Validity of findings was established through extensive data collection and thick, rich description of observations (Creswell and Miller, 2000). Moreover the provision of thick rich description allowed the researcher to gain an understanding of one aspect of participants’ experience, being a Muslim in an Australian hospital.

This research was done in collaboration with a group of Muslims, and they were not a group of ‘subjects’. The researcher was trying to establish a deeply trusting relationship with the participants. A warm and trusting relationship, where both participants and the researcher are committed to better understanding the experience being explored, allows for greater access to richness of participants’ experience (Creswell and Miller, 2000). A strong trusting relationship can provide the surest way to meet and overcome problems associated with the validity, reliability, and trustworthiness of qualitative data.

A verbatim transcript of each interview was created from the audiotape of the interview. Qualitative interview data always brings with it the potential for problems with transcription error. Transcription has been described as central to the process of analysis in that it represents what the researcher perceives from the taped speech. Transcribed text can never totally capture the complexity of the interaction nor be completely error free (Sandelowski, Docherty, and Emden, 1997). All transcripts were proofread and double-checked for accuracy in order to provide the highest level of quality transcription. It took four to six times longer than the length of the tape.

The researcher used a complete audit trail that documents how data were generated and analysed including all notes, documents, analysis materials, events that occurred, and questions that arose during the research process. A qualitative study typically involves a large volume of researcher-generated data, including notes about the context of the
study, methodological decisions, data analysis procedures, and self-awareness of the researcher (Rodgers and Cowles, 1993). Such data are important in many aspects of the study, particularly in the development of an audit trail to substantiate trustworthiness. The purpose of the audit trail is to establish potential credibility of qualitative studies and serves to convince the scientific community of their rigor (Wolf, 2003).

A process of participant validation was used in this study. Participant validation was achieved by ensuring some of the original respondents from the interviews had the opportunity to comment on the data and findings; they were supplied with a copy of their transcript and subsequent theme construction and were asked to comment on the accuracy of analysis (Simonsick et al., 2001).

The researcher kept a reflective process throughout the study in order to reduce the potential for researcher values, beliefs and preconceptions to influence the subsequent findings by using a research diary and field notes made during the interviews and immediately after interviews. Reflecting upon conversations and the circumstances surrounding them often leads to new questions. In addition, the journal allows the researcher to acknowledge and monitor his or her subjectivity. Through the journal, the researcher is better able to notice personal assumptions and biases by observing how their questions have led the conversations in particular directions (Armstrong, 2004).

4.10. Summary

In this chapter, I described the guidelines for conducting this hermeneutic phenomenology. With these guidelines in place, I shared what I was trying to understand through this research project. In addition, the participants, ethical issues, recruitment strategies, and data generation were discussed. The issue of rigour and quality surrounding the use of this approach was discussed in this chapter. The next chapter, Chapter Five, will introduce the research participants and provide the initial
understanding of the phenomenon. Chapter Seven, also, will provide my understanding of what it means to be a Muslim in an Australian hospital.
CHAPTER FIVE
INTRODUCING PARTICIPANTS

5.0. Introduction

The chapter introduces the men and women whose lives are central to this study and provides a brief biography of the research participants with details provided about their age, education, family, home and work situation. This allows the reader to get to know more closely the people involved in the study. The chapter also provides a snapshot of each participant’s hospitalisation experience so as to contextualise each person within the focus of the study.

As previously discussed, the hermeneutic analysis of the textual data drawn from the Muslim patients’ descriptions of their hospitalisation involved a process of moving between the parts of the data and the whole data. The first step in the data analysis process therefore was to immerse myself in the story of each participant, this being the ‘parts’ of the data. This chapter, therefore, serves two purposes, the first being to introduce the reader to each participant and to contextualise each person within the study. Secondly, through the summation of this information, I began to formulate a sense of what each participant was saying in relation to the phenomena, therefore developing a sense of commonality between participants. This process provided a foundational understanding of various parts of the experience in relation to the whole
experience of Being a Muslim patient in a non-Islamic hospital. Thus the chapter includes several vignettes that are an illustration of and insight into the participants, rather than a representation of them. This chapter is organised in the same order that the participants were interviewed.

5.1. The Participants: Overview

The participants consisted of eight females and five males, aged between 26 to 47 years. Chapter Four outlined the processes undertaken to recruit these participants to the study. Each person was assigned a pseudonym to ensure anonymity and preserve her/his confidentiality. In keeping with the study, common and easily recognisable Islamic names were selected as pseudonyms for each participant. Table 6-1 provides a summary of the demographic details of each participant.

At the time of interview, eleven participants were married and living with their family. One woman had been widowed for over five years and one man was single. Their country of birth varied, with Iran and Iraq being most common. The participants all lived in different suburbs of Adelaide within a radius of 40 km. Apart from two participants who lived on farms outside the metropolitan area, they all lived at least a 15 minute drive from the city centre. All participants had lived in South Australia for at least two years.

In this study, some of the interviews were conducted with at least one of the family members present at the time. Although their presence was not required, it was deemed acceptable for family members to be present in the interview session. It is recognised that commonly this type of interview would be conducted with only the researcher and the participant present however in some cases it would have been culturally inappropriate to even request that the family member not be present. However none of the family members had taken an active role in the interview session.
As can be seen in Table 5.1, the duration of hospitalisation ranged from 3 days to 92 days, with the majority being hospitalised for less than a week (median of 5 days).

### Table 5-1: Description of Participants

<table>
<thead>
<tr>
<th>Name (Pseudonym)</th>
<th>Age (Years)</th>
<th>Gender</th>
<th>Nationality</th>
<th>Days in hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fariba</td>
<td>46</td>
<td>F</td>
<td>Iraq</td>
<td>12</td>
</tr>
<tr>
<td>Marzieh</td>
<td>38</td>
<td>F</td>
<td>Iran</td>
<td>92</td>
</tr>
<tr>
<td>Yasamine</td>
<td>42</td>
<td>F</td>
<td>Iran</td>
<td>5</td>
</tr>
<tr>
<td>Sarah</td>
<td>37</td>
<td>F</td>
<td>Syria</td>
<td>3</td>
</tr>
<tr>
<td>Akbar</td>
<td>37</td>
<td>M</td>
<td>Iran</td>
<td>3</td>
</tr>
<tr>
<td>Shakira</td>
<td>34</td>
<td>F</td>
<td>Turkey</td>
<td>18</td>
</tr>
<tr>
<td>Ali</td>
<td>33</td>
<td>M</td>
<td>Iraq</td>
<td>3</td>
</tr>
<tr>
<td>Habib</td>
<td>38</td>
<td>M</td>
<td>Iran</td>
<td>5</td>
</tr>
<tr>
<td>Fatima</td>
<td>45</td>
<td>F</td>
<td>Lebanon</td>
<td>9</td>
</tr>
<tr>
<td>Hamid</td>
<td>26</td>
<td>M</td>
<td>Pakistan</td>
<td>4</td>
</tr>
<tr>
<td>Hussein</td>
<td>29</td>
<td>M</td>
<td>Afghanistan</td>
<td>7</td>
</tr>
<tr>
<td>Huda</td>
<td>42</td>
<td>F</td>
<td>Afghanistan</td>
<td>4</td>
</tr>
<tr>
<td>Yalda</td>
<td>47</td>
<td>F</td>
<td>Iraq</td>
<td>3</td>
</tr>
</tbody>
</table>

### 5.2. Fariba

Fariba is forty-six-year-old woman, married to an agriculture engineer, and is the mother of a twenty-seven-year-old son. She was born and grew up in a religious family in Iraq. Fariba is an Iraqi refugee and a pleasant woman who has lived in Australia since 1998. She is a Muslim and described herself as an Iraqi woman with traditional beliefs, which include the wearing of hijab. She has regularly attended the mosque and participated in the Islamic community since she was a young girl and is at present actively involved in the Islamic community. She is university educated and at the time
of interview was acting as an interpreter in an international resource centre. Her English is unaccented, fluent and essentially accurate.

Fariba was recruited through a key contact person. She was keen to be involved in this research and was the first person to be interviewed. She was also eager to encourage other potential participants to be involved in the research project and agreed to talk to her friends and acquaintances in the Islamic community about the research. Fariba agreed for the interview to be conducted in a quiet room at her workplace.

Fariba started to relate her experience in a relatively calm and matter of fact manner. Fariba’s story described her experience of being admitted to hospital after experiencing severe lower back pain and muscle spasms. Fariba had been admitted to hospital with a herniated lumbar disk, which required surgical diskectomy. Within two days of her surgery, she developed a postoperative complication of a haematoma near the surgical site, prolonging her hospitalisation period by a few days. Otherwise her admission to the hospital was clinically uneventful.

It become evident during the interview that issues related to caregiver gender and hospital food caused her some concern. Due to her Islamic following, she was accustomed to eating halal food (food which is permissible to be consumed by Muslims) and was unaccustomed to having her body exposed in the presence of male persons. However her independent nature allowed her to adjust to these issues while in hospital, albeit not without some consternation.

In terms of food, I knew that the hospital does not provide halal food... it was important that the food to be halal... Well, there were vegetarian foods available that I could eat them. So it was not difficult that I use vegetarian foods for a short period. However some times I liked to eat meat. (Fariba, p. 5:157-163)

Although her story did not follow an orderly sequence, she provided an interesting account of her experience of being a Muslim patient in the hospital. For example, she constantly referred to the perceived lack of knowledge among health professionals about appropriate specific needs of Muslims and the importance of allowing Muslim patients to have more say in their care. As Fariba explained:
I think, he [the nurse] did not know how much it was important for me as a Muslim woman to be looked after by a female nurse.... Sometimes, I was crying during changing position and giving massages my back, he was supposing that I have pain. He frequently was asking me for some painkiller. (Fariba, p. 3:102-111)

As Fariba was the first person to be interviewed, I was left feeling rather frustrated and dissatisfied with this particular interview. I felt that I had not been successful in gaining any real depth in our conversation. However I learnt a lot from the initial interactions with Fariba. The interview proved to be a valuable learning experience, particularly in relation to the importance of firstly establishing rapport and trust with participants before asking them to share their personal feelings and thoughts with a relative stranger. The experience of this first interview guided the subsequent participant interviews and interactions.

5.3. Marzieh

Marzieh was in her late thirties, married to an Iranian man for ten years with two children, one nine-year-old girl and a three-year-old boy. Marzieh was born and grew up in Rasht, the north of Iran, and moved to Australia in 2000. She was a professional midwife in Iran and left her job before coming to Australia. In keeping with Islamic culture, Marzieh was a Muslim woman wearing a headscarf.

Marzieh was recruited to participate in the study through the snowball sampling technique. The interview was conducted in the presence of her husband in the well-furnished living room of Marzieh’s home in one of the northern suburbs of Adelaide. During the interview, Marzieh preferred to speak in Farsi and therefore her story was later translated and transcribed into English by the researcher who was familiar with Farsi language.

At the beginning of the interview, Marzieh appeared nervous and was breathing heavily but as the interview progressed, she appeared to relax and become more comfortable
with the interview process. Marzieh spoke about her hospital experience three years earlier, after being admitted for treatment of serious complications experienced during her pregnancy. She was hospitalised for a three-month-period until her son was born.

During the interview, Marzieh described the need for frequent gynaecology examinations and how her first gynaecology examination was extremely painful and that she felt uncomfortable and helpless when the doctor in the emergency department was male.

*There was no way I had to be examined by him [the doctor in the emergency Department] ...I think, the emergency department staffs did not treat me as a Muslim woman. There was not much that I could do, except accepting the existing situation. ...I felt helpless and unable to do very much because of my situation at that time. I could not refuse the examination.* (Marzieh, p. 6:232-237)

Marzieh was afraid to refuse to have the examination when she was in the emergency department because of the seriousness of her condition at that time. However, when she was more stable and was transferred to the maternity ward she asked to have a female doctor. She said this decreased her anxiety.

Although in general her experience of being in the hospital was extremely positive, Marzieh found some issues of concern arose, such as limited privacy, appropriateness of food, lack of support and conversing in English was problematic. She said:

*Being a shared room was hard. I should wear my head cover all times or should keep close the curtains because the lady who was next to me had many visitors. They [the hospital staff] did not know exactly why I was hiding myself behind the curtains. I thought that I had to introduce about what I actually preferred. However, I had fear because of my English... I also feared that they might not accept my desperate need. But they really considered my request for a private room when I asked.* (Marzieh, p. 8:321-326)
5.4. Yasamine

Yasamine is forty-two-year-old married woman and mother of two teenagers, aged fourteen and sixteen years. Originally from Iran, Yasamine moved to Australia in the 1990s, eventually settling in South Australia in 1994. Her husband, a molecular plant biologist, was also from Iran. Both attended Iranian universities prior to immigration, however, Yasamine did not complete her studies. In Iran, she worked part time as a secretary. Yasamine was born to a religious middle class family in Shiraz, the capital of Fars state. At the age of six, she entered an Islamic school to learn to recite the Quran and when she was ten years old, she entered public school.

Marzieh informed Yasamine about the research study and so she volunteered to participate because she believed this and other studies would assist health professionals in the provision of health care for Muslims. The interview was conducted in Yasamine’s house in one of the western suburbs of Adelaide. I was made to feel very welcome in their home speaking openly about the research with Yasamine’s husband during supper prior to the interview. Farsi was her dominant language and although she was willing to communicate in English, the interview was conducted in Farsi language.

At the beginning of the interview, Yasamine discussed how after a motor accident she was hospitalised for five days. She had a fracture in her left wrist and elbow, which required surgical treatment. Yasamine had severe pain, with stiffness and numbness in her left hand. Her recovery was uneventful and she was discharged three days following surgery. She continued to visit the hospital for physiotherapy and further outpatient treatment for one month after discharge.

During the interview with Yasamine, much of her story related to her experience in the operating room. She told her story with precision, explaining how the nurses prepared her for the operating room and how this made her feel. She explained the difficulty she had when asked to remove her hijab before surgery. Like Marzieh, she emphasised the importance of hijab in her life and stressed the discomfort that she felt with not being able to wear her appropriate attire.
I consider wearing the hijab an act of belief... Without it I feel uncomfortable. It is not optional. Islam requires it... If need be I would have worn the bandana, but it is also no longer permitted in the operating room. (Yasamine, p. 11:446-447)

When prompted to say how she felt about taking off her hijab, she said:

I would like to cry. (Yasamine, p. 13:524)

Yasamine said, although she felt scared and helpless, she asked the nurse about whether she could be appropriately dressed.

At the time, I was ready to wrap a piece of cloth [around my head]. Anything ...[to] cover my body and hair including the sheet and the blanket, it was a valuable to see how the nurse was searching for and what she did to ... [cover] my body and hair. (Yasamine, pp. 11-12:439-441)

Yasamine was generally pleased with the hospital services and the friendly nurses who were in the ward, stating that most nurses were supportive. However, she expressed frustration with the behaviour and action of the nurse in the operating room because of how she looked at her with the makeshift hijab. In fact, she expressed that while awaiting surgery in the operating suite she felt uncomfortable and under pressure because of her appearance.

5.5. Sarah

The fourth participant was Sarah, a thirty-seven-years-old woman from Syria. Sarah and her husband have been married for over ten years but they have no children. They have lived in Australia for three years. Sarah was a University qualified registered midwife with more than five years work experience and wanted to live with her husband, a postgraduate student in soil biology, in Australia. Sarah grew up in a religious environment, strongly encouraged by her father to practice Islam who taught her the principles. She also studied religion from an early age in Islamic schools.
Sarah was encouraged by her husband, a student at the University who became aware of the study through meetings in the Muslims’ prayer room, to participate in the study. The interview was conducted at Sarah’s home in the presence of her husband.

Sarah spent three days in hospital with an acute middle ear infection requiring surgical intervention. The interview was undertaken eight months after she was discharged from the hospital. When first admitted to hospital, she had severe pain in her ears, fever, chills, nausea and vomiting. Surgery was recommended to decrease pressure in her middle ear, particularly when medication did not relieve her pain.

Sarah shared with me her experience of how difficult it was to bring some soil in order to do Tayamom (ablution by sand or soil). As Sarah knew this practice would not be familiar to Australian healthcare workers, and that it might seem strange to them, she felt guilty and uneasy about bringing the soil into hospital. Sarah explained how being in an Australian hospital was one of the most challenging experiences in her life and she had the sense of belonging to another place. She felt like a foreigner, surrounded by people whose values, perspectives, behaviours, and attitudes that are in direct contrast to her own. The sense of belonging to a different culture constantly reinforced her awareness of being different. Sarah started to ask herself questions like:

*Why are they doing it this way and we are doing it in another way?* (Sarah, p. 17, L: 509)

Despite this, she did believe that it was a valuable experience and she had the opportunity to meet people who grew up in a different culture.

### 5.6. Akbar

Akbar was in his early forties, married with two young children. Akbar is an immigrant from Iran who moved to Australia in 1993. When his daughter, Yasi, was born in 1996, they returned to Iran, but moved back to Australia in 1999 when his son, Amin, was
born. Himself born in Tehran, he grew up in a religious family and learnt to recite the Quran when he was a six-year old. He went to University and later collaborated with the Iranian national movement for constitution change and liberty, and was injured during the Islamic revolution of Iran. He is a devote follower of Islamic principles.

Akbar was identified as a potential participant while in hospital. After I met with him, he agreed to be involved in the study and the interview was planned to take place in his home after discharge.

Prior to the interview, Akbar spoke about the days before immigrating to Australia. He spoke in a calm, friendly manner, was very confident, convincing, and cooperative. Akbar preferred to have the interview conducted in Farsi, despite being familiar with English.

Akbar had suffered from chronic sinusitis for a long time. After trying a number of medical treatments, he still suffered from headache, ear pain, bad breath, and nasal discharge. Akbar was referred to a surgical specialist and admitted to hospital with a diagnosis of chronic maxillary sinusitis requiring surgery to alleviate his symptoms.

Akbar was pleasant and grateful for everything the nurses had done for him.

*Everything was so nice to me there. They [nurses] take their time ... they were the best.* (Akbar, p. 21:809-812)

He was highly satisfied with his in-patient experience and the services provided by the hospital. However he did recount some problems associated with the food. Akbar recalled, when his appetite was very poor he liked to eat meat.

*I wanted to ask them [nurses] why there was not halal. But I was not confident to ask my need.* (Akbar, p. 24:921-922)

Akbar criticised hospital administrations and said hospitals that admit Muslims need to provide food according to Islamic dietary principles.
5.7. Shakira

Shakira was a thirty-four-year-old housewife, originally from Turkey. She is married to an accountant, and they have two children. At the time of interview, Shakira was a third-year university student. Shakira was born in Istanbul where she completed her early schooling and graduated from high school in 1989. After the completion of her secondary education, Shakira’s family moved to Australia. Shakira is a Muslim but does not regularly pray or wear head cover (hijab).

Shakira was told about the study from a previous participant. After I met her to discuss the research and the process of the interview, she agreed to take part. We also organised for the interview to take place in her home. The interview was conducted in the small living room, which comprises the front part the house, in the presence of her family, her husband and her sons.

I noted that Shakira seemed very restless and distracted when I asked her to consent to the interview. Being conscious of her reluctance I decided to go over the details of the study answering any questions and reinforced that she would not be identifiable. She seemed more at ease and consented to participate.

Shakira had been hospitalised for childbirth in 2001. Her newborn was alert and active and started breast-feeding after a normal delivery. On the second day after delivery she became concerned about her baby’s health and repeatedly notified nurses and doctors that she felt something was wrong with the baby. However, they did not agree and she believed that they neglected her baby. Shakira’s baby died from an unknown cause and she did not give permission for an autopsy.

It was obvious that recalling this experience caused Shakira distress as she was unsettled and periodically her eyes filled with tears, as she endured the pain of talking about her baby. When I suggested that I turn the audiotape off and take a break, she accepted. After coffee, and when she was more composed, we resumed the interview.
I felt that Shakira tried to relay two critical points of view. The first was that although the focus of healthcare was aimed at the majority of people, being of a Western culture, non-Islamic hospitals did not provide for Muslims’ basic needs due to lack of understanding and resources. An example of this related to procedures after the death of her baby.

*Each religion has specific burial procedures and Islam is no exception. That was a really important one for us as Muslims because we wanted to bury our baby with a proper and dignified Islamic funeral... I was in complete shock when I heard my husband did funeral for our child because nobody [the hospital staffs] knows how to do funeral in Islamic way.* (Shakira, p. 28:1122-1127)

Her second concern was that she felt discriminated against because of her religious affiliation. She did not feel as if she was treated in the same way as non-Muslim patients. She said the provision of Australian health system is exclusively dedicated to the unconditional principles of the Anglo-Saxon culture and felt this could lead to substantial direct and indirect discrimination and accounted for negativity by Muslims. She said:

*In order to ensure that the health care needs of Muslims are tackled, specific care that responds to Muslims’ special health needs should be taken into account and hospitals as a service provider must be more sensitive to the religious issues that can arise when a Muslim request to be treated Islamically.* (Shakira, pp. 29-30:1160-1163)

I found Shakira to be a very assertive, confident woman who definitely had a sense of herself. It was obvious from her interview that she has learnt a great deal from her experiences in hospital and that she was able to express her feelings and perceptions.

### 5.8. Ali

At the time of interview, Ali was thirty-three year old, married, and father of two girls, two and six years of age. He was born in a small rural town near Basra city, Iraq and
grew up in Najaf, one of the religious cities in Iraq. Ali moved to Australia as an Iraqi refugee in 1991. Ali’s parents taught their children to follow Islamic principles as their custom from childhood. Ali began his activities with Islamic associations, participating in classes of commentary on the Quran. He was a practicing priest in Iraq prior to coming to Australia. Ali is currently teaching the Arabic language to Iraqi children as a voluntary job and his family receives a state pension.

Ali found out about the study from an Islamic medical officer at the hospital. We made contact over the telephone and he agreed to be interviewed in his home. My first impression of Ali was that he was a friendly person.

Ali clearly remembered when the first symptoms of a firm mass appeared over his right calf. He recalled how the tumour was painless at the beginning and progressively enlarged, however Ali was reluctant to go to the general practitioner (GP) because he was concerned about his difficulties with English language. However when the pain became severe he was forced to go to the GP. A Computer Tomograph scan revealed a relatively soft tissue mass between the muscles in his leg.

Ali was hospitalised for surgery in order to remove the tumour. He discussed that:

*It was not a simple issue for me but I thought there is no choice because I was in terrible pain and my leg was almost completely swollen.* (Ali, p. 31:1212-1213)

When I asked why he did not want to be in the hospital, Ali looked at me incredulously and said:

*I had problems related to communication. No one wants to be in hospital if they are not able to speak English.* (Ali, p. 31:1215-1216)

When I asked why he did not ask for an interpreter, he responded:

*Interpreters were not specialist trained for professionals working in the field... Sometimes, I had to correct what the interpreter was saying to the doctor.* (Ali, p. 31:1221-1325)
He added:

>I expected other problems that were related to my religious beliefs. For me, my religion is important and the priority is on my religion. (Ali, p. 32:1246-1248)

Ali believed that although the hospital services were directed to other aspects of cultural needs, there were insufficient services to provide for Muslims’ religious needs. He highlighted some problems that he faced during his hospitalisation associated with his religious affiliation and from being a Muslim patient, such as praying, food provision, and a stressful social interaction.

Ali voiced a concern about the acceptability of Muslims and their religious practices amongst non-Muslim health professionals and was concerned about how they would react. There were fears of discrimination, and the consequences of that for Muslim patients. He had particular reservations about talking about his religion and explaining his needs while in hospital because he was afraid of being discriminated against.

5.9. Habib

Habib was in his late thirties, married to a teacher and they have three children, two girls aged seventeen and thirteen and a boy aged nineteen. He was born and grew up in an extended family in Iran. Habib and his family migrated to Australia in 1993. He is a Muslim who manages a restaurant.

A previous participant had encouraged Habib to be involved in the study. After making contact we arranged for the interview to take place at his house in a rural area south of the city.

Habib had been hospitalised five times in the last couple years due to diabetes and so could talk confidently about being in hospital. He had been diagnosed with diabetes type II at the age of thirty-two. Habib was very happy with the hospital services,
especially expressing that staff were incredibly supportive and caring in comparison to his previous experience in Iran. Although a Muslim, Habib was not a fundamentalist and did not practice all Islamic principles, such as strict dietary requirements for Muslim people. However, Habib reported a feeling of being different from other people and said this was the hardest experience that he had. He believed this feeling took root in his religious affiliation. He said to me that:

_For me, being different as a Muslim patient was something to have the silence surrounding abuse and everything related to that._ (Habib, p. 37:1478-1480)

He was afraid of being different, having no one to talk to, and little support because of his religion. Habib recalled feeling that other patients were not interested in listening to him. He added:

_I felt lonely, because that I was thinking no one cared to listen to my needs and how I felt._ (Habib, p. 38:1482-1483)

### 5.10. Fatmeh

Fatmeh is a forty-five-year-old Lebanese married housewife, without children. Fatmeh was born in the North Bekaa valley in Lebanon but her family migrated to Australia when she was four years old. She lives on a small acreage together with her husband and her brother’s family in a northwest suburb where she grew up. Fatmeh is a Muslim who grew up in Australia. She believes in God, in his prophet Mohammad, and in the Quran and chooses to wear a headscarf. Fatmeh speaks English with virtually no accent. She uses her native tongue, Arabic, only when she is with her family.

Fatmeh was recruited while in hospital through contact with the chaplaincy service. I made contact with her at that time and we arranged for the interview to be conducted at her home after hospital discharge.
Fatmeh noticed she had increasing fatigue and breathlessness at night. When she spoke to her husband about these unusual symptoms, he dismissed them. Over the course of two years, she visited her family doctor several times. She tried to describe the symptoms. She believed that her family doctor was frustrated because he could not make sense of the symptoms. Her family doctor diagnosed heart failure and referred her to a cardiologist who confirmed the diagnosis. Since that time Fatmeh had been hospitalised many times for complications related to heart failure.

Her overall perception of hospitalisation was that it was a very pleasant experience. Fatmeh considers herself to be a traditional Muslim but was trying to adjust to a new culture and adhere to health beliefs that differed significantly from Islamic practice. I did not get the impression that Fatmeh’s religious beliefs had much influence over her life choices. Although she cared about her Islamic beliefs, she had no difficulty in adapting to conditions in a non-Islamic hospital. As she said to me that:

*I have lived in Australia for a long time, over forty years, since I was a child. I have got used to Australian culture. I did not have any problem at all. Everything was okay.* (Fatemeh, p. 45:1786-1788)

### 5.11. Hamid

Hamid is twenty-six-year-old single man and a university student who has lived alone in Australia for a year. Hamid was born and grew up in an extended family that practice Islam in Islamabad, Pakistan. He was one of the ten children.

Hamid was also recruited in hospital and was eager to be interviewed when I contacted him. I interviewed Hamid a week after discharge from the hospital in a quiet room in the University, as this was most convenient for him.

Hamid began by explaining that he was relatively well in the past. He began to suffer abdominal pain and intermittent fever for about a week. He also complained of anorexia, diarrhea and vomiting and when the pain became severe he visited the
Emergency Department. He was diagnosed with acute appendicitis and went to surgery for an appendicectomy.

Hamid was very thankful that everywhere he went people were kind and professional. He was promptly seen by the doctor and did not have to wait for treatment. The only thought in his mind at that time was to stop feeling so unwell. He was quite prepared to let the health care professionals do what they needed to do in order to alleviate his condition.

The importance of family support in Islamic culture, lack of health care professionals’ knowledge and a positive experience of hospital care were the focus of his story. Hamid’s experience is replete with this sense of being unprepared for the illness and how lack of familiarity and preparation for what was taking place made him feel uncertain and lonely. He said:

> You know I liked my family and my friends were here. After all, when you are in hospital, you like to see your close family and friends are around.  
(Hamid, p. 48, L: 4120-1422)

Hamid shared with me some of the challenges he faced while in hospital such as his dietary and prayer needs and that he felt the hospital staff did not know much about Muslims.

### 5.12. Hussein

Hussein is in his late twenties, a refugee from Afghanistan. He is married and has one child, a girl aged one and half. Hussein moved with his family from Afghanistan to Pakistan and then to Australia in 2002. Hussein was born in what he described as a farming-class family in Herat, Afghanistan. Hussein’s father encouraged him to learn about Islam. He was in contact with several religious persons in order to form his life as a Muslim. Hussein performs Islamic prayers five times a day and recites the Quran.
regularly to develop his faith. He had only four years of formal education in Afghanistan.

Hussein was recruited in hospital where I met with him before discharge. Our first meeting was brief but we discussed and planned that the interview would be done at his home. The interview was conducted in Farsi because his English was poor.

Hussein was had been in the hospital for a week and had surgery to remove renal stones. He had severe colicy pain in his right flank for few days before hospitalisation which one night became suddenly worse, radiating from his back into the groin area. The pain was accompanied by nausea and vomiting. He had surgery to remove the renal stones the next day after admission.

Generally, it was difficult for him to recall his story in a logical order. Hussein, like most of the participants, gave a positive impression of the conditions in the hospital and that he was cared for appropriately.

> It was weird but they [nurses] were kind to me. I am glad that I have such fantastic experience. (Hussein, p. 51, L: 1508-1509)

But he clarified that:

> When I say it was fantastic, one does not mean I had no problem at all. (Hussein, p. 53, L: 1572-1573)

He added:

> [Some] nurses assume illness or sickness and they don't talk to you about who you are within that illness. They just assume you're there and this is what you need to be taken care of. It's like you don't have a history or anything. (Hussein, p. 54, L: 1615-1619)

He related a story about his frustration to communicate with nurses about his needs.

> Well I was not able to tell them I have to pray. I didn’t know how I would explain that I have to pray. It was annoying. ...So I just put a newspaper on the floor and showed what I wanted to do. (Hussein, p. 53, L: 1586-1589)
5.13. Huda

At the time of interview, Huda was a forty-two-year-old widowed mother of two teenagers aged fourteen and seventeen. She was born and got married in Afghanistan and her husband passed away in the Afghanistan war not long after her youngest daughter was born. Although she considers herself a Muslim woman, she decided not to practice all the Islamic principles when she moved to Australia, such as wearing the hajib and eating food prepared according to Islamic dietary laws.

I recruited Huda while in hospital and we met two months after discharge to conduct the interview in her home north of the city. Before the interview started, I was offered some hot tea and cream biscuits. Huda asked if her daughters could be present for the interview. Since her English was still poor, the interview was conducted in Farsi.

She stated she had no serious health problems in the past, except arthritis. She was hospitalised due to severe vomiting, abdominal pain, and fever about five months ago. Various examination and tests were done to find out the cause of her problems, eventually diagnosed with acute gastritis. With antibiotic therapy, the symptoms resolved. After an uneventful stay at the hospital, Huda returned home.

Huda had mixed opinions in terms of her satisfaction with the provided hospital services. At times she was satisfied and other times not. For example, she was happy with the interpreting service, despite reporting that her daughter had to occasionally correct what the interpreter was saying to the doctor.
5.14. Yalda

At the age of forty-seven, Yalda was the oldest participant in this study. She is married and a mother of two children, aged nineteen and twenty-two years old. Yalda was born and grew up in Baghdad, the capital city of Iraq. Although Yalda is university-educated, she is currently unemployed. Yalda’s family are refugees and who have lived in Australia since 2001. As a Muslim woman, she adheres to certain norms of modesty and covers her hair as a symbol of her religion.

Yalda was recruited to this study through snowball sampling. The interview was conducted over two years after discharge from the hospital. Like other women in this research, the interview was done in presence of her husband and children.

Yalda described how abdominal discomfort led her to be in hospital for a few days. Yalda clearly remembers when the first symptoms of abdominal pain appeared. She noticed some abdominal discomfort in the afternoon. She was in agony by dinnertime and her husband drove her to emergency room and three hours later, she was diagnosed with acute cholecystitis. The next morning she had an ultrasound and a surgical consult. The surgeon told her that the gallbladder should be removed. She had her gallbladder removed in the afternoon.

Yalda expressed these sentiments about hospitalisation:

> Once it has been determined that hospitalisation is necessary, you may have a choice of what hospital to go to. But for me it was no matter which hospital I go at that time. I knew it is different from my expectation. ...I did not expect that they respond to my diverse needs but I was sure that I would be in a safe place where they try to treat me in an appropriate way. (Yalda, p. 61, L: 1811-1825)

Yalda related a story that everything seems normal in the Islamic hospitals for Muslim patients.

> When I was in an Iraqi hospital, I never thought how they [caregivers] treat me. I guess everything was normal for me in there. But I didn’t feel like this here [the Australian hospital]. (Yalda, p. 61-62, L: 1830-1832)
However she said to me that:

...Hopefully if you go you can get things straighten out. It’s nothing to be scared about. They are there to help and want you to talk [to] them when you are having problems. It was no matter that other patients on the ward had different expectations and different needs. (Yalda, p. 62, L: 1849-1853)

Yalda’s impression was very positive even though she did refer to some of issues and concerns in the hospital setting, such as gender and dress code.

By the end of Yalda’s interview I recognised many common issues that had been raised by the other participants. At this time I began to sense that no new issues were emerging and that this would be my final interview.

5.15. Summary

The purpose of this chapter was to provide an illustration of and insight into the research participants in this study. The chapter has introduced the thirteen participants who volunteered to participate. The interviews provided the opportunity to obtain the participants’ perspective of what it was like for them to be a Muslim patient in an Australian hospital. Although each person’s perspective is different, some commonalties are threaded throughout.

Having carefully read each participants story in order to summarise their contextual relationship to the phenomena, I had became emerged in the ‘parts’ of the phenomenon, this being the first step in the data analysis process. Recognising these commonalities left me with an overall impression of dominant concepts that were the beginning of what would, after further analysis, form the ‘whole’ picture that describes and gives meaning to Being a Muslim person in a non-Islamic hospital. The next Chapter, Chapter Six, will explain the process of data analysis.
6.0. Introduction

This chapter discusses in detail the process of finding meaning, which presents a step-by-step ontological account of the meaning participants attributed to the phenomenon of being a Muslim patient in a non-Islamic hospital. The first section of this chapter explains how Gadamerian philosophy can contribute to an understanding of the phenomenon of interest. It is then followed by reflexive activities, which were used in the process of data analysis. The chapter also presents the approach taken for the thematic analysis of participants’ lived experience of phenomenon. The chapter ends with interpretive activities which were applied during the process.

6.1. The Process of Data Analysis: an Overview

One of the greatest challenges in my study was to select a method for data analysis and interpretation that was congruent with the philosophical underpinning of the Gadamerian hermeneutic tradition. This was a challenge for a number of reasons. First, there were no formal guidelines or typical exemplars presented within the literature to
guide the analysis of the qualitative data. For example, although Grbich (1999) identifies four ideal modes of analytical procedures for qualitative research, little information is given on how to use these modes in the process of data analysis. Roberts and Taylor (1998, p. 109) assert many of “phenomenological methods leave prospective researchers wondering just what to do”. Further Caelli (2001, p. 273) says researchers "must look long and hard to find materials to assist them in developing their research plans".

The second reason is that numerous research books have chapters which provide qualitative data analysis methods, but many of these texts discuss qualitative data analysis in a superficial manner (Nieswiadomy, 1993). Thus, the extent to which the researcher has access to information regarding how to undertake data analysis with a particular philosophical orientation in mind is limited, and tacitly a message is given that there is little need to consider philosophical orientation when devising one’s method of analysis (Turner, 2003).

This section provides the detail of how the data analysis was done from a preliminary descriptive analysis of the text through the components of the analytical process to the representation of the themes that emerged from the interview transcriptions. It explains the steps and processes used to make sense of the data, with guidance from the work of Gadamer (1989) and van Manen (1990). It also explains how the thematic analysis was conducted in order to identify sub-themes and themes.

### 6.2. Analysis informed by Gadamer

In this research, a Gadamerian hermeneutic approach was taken to achieve a deep understanding of the phenomena of being a Muslim patient in a non-Islamic hospital. Gadamer (1989, p.295) inferred that “hermeneutic work is based on polarity of familiarity and strangeness … the true locus of hermeneutics is this in between”. Because of the intermediate position in which hermeneutics operates, its aim is to
clarify the conditions under which understanding occurs (Gadamer, 1989). Conditions under which understanding occurs “… do not amount to a procedure or method which the interpreter must of himself bring to bear on the context” (Gadamer, 1989, p. 295).

Significant concepts from Gadamer (1989) were embraced throughout the conduct of this study, including notions of hermeneutic circle of pre-understanding, gaining understanding through dialogue with participants and the text, and fusion of horizons. Thus the process of understanding was generated from within a series of three distinct but open-ended phases of the hermeneutic circle: from developing a research question, to dialogues held with the participants, and the interpreting of the transcripts. The following paragraphs provide detail on each of Gadamer’s concepts, which were used in this study in order to analyse data.

6.2.1. Identification of pre-understandings

The term ‘pre-understanding’ refers to the required knowledge one needs to understand and deal with a problem. It includes specific experiences and encounters with the text that tend to make us assume that we already understand it (Gadamer, 1983). Pre-understanding not only is the starting point of hermeneutics, but also it is formed and reformed through a hermeneutic process in order to generate and interpret data. Pre-understanding, therefore, could change during the research process through the collection and interpretation of data, further relevant reading and the keeping of a research journal. For example, my pre-understanding has changed throughout the research and I understood that Islam should not be considered merely as religion. Islam is a culture, a complete system of life-transaction which affects every aspects of Muslims’ life. Islam transforms people’s outlook on life and shapes the way Muslims live. I found Islam has never been bound by cultural, geographical and ethnic considerations. It is for this reason that we find such strong symmetry amongst culturally, racially and geographically diverse Muslims from South Asia to West Africa as well as in Western countries.
For me as the researcher, this meant that throughout the analysis I needed to maintain openness to the possibility of changing my initial concepts of pre-understanding and interpretation and that the outcome of data analysis was continually being reassessed as new concepts came to light. According to Elster et al. (2003), researchers are enabled to enter the hermeneutic circle by explicating and periodically reviewing their pre-understandings in order to discover something new or understand something in a new way. “A researcher’s pre-understanding develops iteratively in the course of the research process on to new levels, which makes it difficult to retrospectively explicate the actual development process” (Holmlund, 1997, p. 21).

My pre-understandings were informed by, my cultural background, the literature review undertaken for this research, and my previously unquestioned assumptions formed from my own life experiences. As a Muslim person who grew up in an Islamic culture, I was familiar and accepting of the concepts of Islamic philosophy and beliefs of this particular population. Islamic philosophy may be defined in a number of different ways, but the perspective taken here is that it represents the style of philosophy produced within the framework of Islamic culture and Islamic philosophy means the philosophy of Muslims. Therefore, at times my own pre-understandings resonated with those of the participants and were useful in gaining an understanding of the phenomena.

Another pre-understanding had to do with the view of Muslims, formed through reading of published accounts of Islamic culture. In the health care context, I understood that Islam provides the framework that shapes Muslims lives and that the meaning of health and illness are influenced by religious beliefs as well as biomedical concepts. For Islamic people health is a composite of physical, emotional, psychological and religious aspects of health, and balance is essential both between and within each dimension. Muslims believe the body should be returned to its Creator in as perfect a state as possible, without mutilation. Again, being familiar with these pre-understandings about Islamic issues helped me as the researcher to understand and make sense of concepts that arose during analysis in relation to participants’ healthcare beliefs and expectations.
6.2.2. Gaining understanding through dialogue

Gadamer (1989) says that understanding may only be possible through dialogue, with researchers being open to the opinion of the other. In this case, the notion of dialogue is not restricted to a conversation between two people; it is also possible to have a dialogue between reader and text. In both instances language is considered the constitutive moment and it is through language that understanding becomes possible (Fleming, Gaidys, and Robb, 2003).

As each participant described his/her experience to me, they were in a process of articulating what the phenomena meant to them. The participants had no single meaning for their experience but rather a multiplicity of partial meanings that were situated and momentary in nature.

Chapter Four described that following each interview, the audiotape was transcribed verbatim to create the text for analysis. Once the text was completed, I listened to the audiotapes and read the texts simultaneously again and again to obtain a sense and cursory impression of the overall story that this collection of people were sharing. This step involved a process of dialogue with the text where I found myself asking questions such as ‘What does this mean for this person?’; ‘Are these concepts linked and familiar to those expressed by another participant?’ Throughout this process I engaged extensively with ideas as they began to emerge, and formed projections about the whole of each participant’s story of being a Muslim patient, embracing some prejudices over others. These initial interpretations became the beginning of the overall picture that was forming – the parts of interpretation (van Manen, 1990/1997). I attempted as much as possible to remain open to the text and avoided making the interpretation fit into some theoretical explanation. Sufficient and initial understanding of the phenomenon was already reached at the conclusion of this stage of data analysis and these parts of the story were presented in Chapter Five where each participant is introduced.
5.2.3. Fusion of horizons

Understanding will appear through the fusion of the horizons of the participants and the researcher. The horizon is the field of vision, which includes and comprises everything that can be seen from one perspective (Gadamer, 1989). However, as the horizon of the present is in continuous development, gaining an understanding of the participants’ stories and reflecting on the researcher pre-understandings will merge into a new understanding of the phenomena. During this phase of analysis, the researcher should attempt to understand how their own personal feelings and experiences (pre-understandings) affect or influence the final interpretation of understanding and meaning for these participants (Fleming, Gaidys, and Robb, 2003).

Utilising Gadamer’s philosophy of understanding, the researcher fully accepted the belief that the task of understanding is never entirely finished, because there is an infinite capacity to refine and extend understanding of things. It is highly likely that if the researcher interacts with the data in years to come the researcher will see the phenomenon differently. Also, each person who reads a report of the findings will also see these data in different ways, bringing their own horizons into play. These comments are not given as an excuse for conceptual sloppiness, nor are they meant to imply that there was a lack of rigor in exploring the data. They are, however, consistent with the methodology of this study, which acknowledged that understanding has multiple realities and multiple, almost endless possibilities.

Taking account of this step in the research process and trying to remain open to new and alternate views as they emerged, this phase of data analysis was accompanied by feelings of personal tension and anxiety, as I was mindful to produce an overall interpretation that was meaningful and worthy of consideration by those interested in this phenomenon and that was true to the participants. I was aware that my own horizons are unique and constantly forming. They were shaped not only by my past and my awareness of the present, but also by the fact that my understanding was changing over time. Throughout the time of this study, my understanding of the phenomenon was continually evolving not only by what the study participants told me, but also through the literature.
I tried to make sense of the totality of what the study participants shared by fusing their ideas, the parts of the study, to create a cogent whole that could articulate the phenomenon of being a Muslim in an Australian hospital. This involved a constant movement back and forwards, hermeneutic circle, from the parts (the participants’ stories) to the whole picture that described the phenomena and is consistent with van Manen’s sixth step “balancing the research context by considering the parts and whole” (van Manen, 1990, p.31).

As I engaged in this process, dominant horizons of the phenomenon became apparent which defined the essence of being a Muslim in an Australian hospital. The final interpretation provided an understanding of this phenomenon from the perspective of those engaged in its explication.

6.3. Reflexive activities

From the pragmatics of a research method, a beginning of my interpretation of the participants experience needs to be identified. On reflection, this beginning occurred with the inception of an inchoate yet compelling question: ‘What is the experience like for a Muslim admitted to an Australian hospital?’ This question did not simply appear from nowhere. Rather, this question arose from within a totality of other questions. Although my interpretations can appear to begin with this question, there really is no true end or beginning to the ontological circle of question, interpretation, and understanding.

Nevertheless, this question placed me within a process of meaning where I realised that my potential understanding was limited only by the question I chose to ask. Each question I asked generated many others. Questioning my present understandings and interpretations became the constant energy in my effort to generate an understanding of the Muslims’ experiences. The questions created a necessary tension between what I
know, shared, and what I anticipated could still be realised or understood. The constant effort to question my present understandings of the Muslim patients’ experience was very important. All these questions were, however, only a reflection of what is happening for the patients from an Islamic background in Australian hospitals.

Consequently, my understanding about Muslims could dictate that only certain kinds of information would be elicited, that the findings had to make sense in terms of the analytical categories, and that these data unquestioningly reflected real events in the experience of the participants. I needed to acknowledge that my understanding had influenced the way I read, received and understood the text and my understanding moved towards a clearer overall understanding as texts were interpreted and reinterpreted. During the research process I became committed to seeking further understanding that was directly informed by Muslim patients.

6.4. Thematic analysis

During the interpretive process the data were subjected to thematic analysis. Thematic analysis has been defined as the process through which meanings inherent in the textual data are identified and described (Luborsky, 1994). Through thematic analysis I recovered recurrent themes that were “embodied and dramatised in the evolving meanings and imagery of the work” (van Manen, 1990, p. 78). I used the term ‘theme’ to describe the dominant overarching meanings of Being a Muslim patient (Coffey and Atkinson, 1996).

van Manen (1990/1997) states themes can be isolated through three approaches: a) Wholistic or sententious approach where we attend to the text as a whole and capture its fundamental meaning; b) Selective or highlighting approach where we repeatedly read the text and examine the meaning of statements which are particularly revealing; and c) A detailed or line-by-line approach where we study every sentence or sentence cluster to determine what it said about the experience. In this study, I used these approaches in
order to isolate themes from the transcripts. I describe how this process transpired in the following section.

6.4.1. Wholistic approach

In the first step of the data analysis, I began to read separately each transcript several times and engaged all the text in order to gain a sense of the overall experience of each participant in order to enable “thickly conceptualise materials” (Denzin and Lincoln, 2002, p.511) to be used throughout Chapter Five where the participants are introduced.

Using the wholistic approach, I treated the data as a whole and deliberately searched for patterns in ideas and recursive thoughts that were expressed, as well as singular or unique ideas. This approach involved moving from the parts to the whole (van Manen, 1990/1997). I made notes about key ideas in the margins. I was eagerly looking for points of similarity, as well as differences, between each participant’s expressions of being a Muslim.

I realised a number of the participants shared the experience of life in a different milieu during their hospitalisation and this was concerned with their life style, customs, and practices. I found the core meaning of the phenomenon emerging through this process. This core meaning was an important representation of the data in this study. This is not to suggest that the core meaning was formed in totality at this point and that themes and sub-themes were then derived from this core them. The development of concepts, sub-themes, and themes is not a linear but cyclical process. The wholistic approach brings an emergence of the core meaning of the phenomenon by examining the parts and considering them in totality.

6.4.2. Selective approach

The selective approach involved analysing each interview transcript separately and moved from the parts (the participants’ stories) to the whole picture of the phenomenon.
Selective reading was undertaken where significant statements, related to and illustrated the various dimensions of the emerging sub-themes and themes that were identified and demarcated. The interview transcripts were read and reread and statements or phrases that seem particularly essential or revealing about the phenomenon of being a Muslim patient were highlighted. Then these individual units from each interview transcript were copied and transferred onto separate computer-spread sheets. This technique was helpful because as I looked at the data sets, I was able to make comparisons with the original text and in the context in which it was said. Once this process was completed for all the transcriptions, the units became linked to keywords in order to formulate conceptual meanings and explore essential qualities of described experiences. This process continued until all data were classified. The conceptual meanings were grouped into similar topics to reflect sub-themes. In the final analysis, sub-themes were grouped to identify themes.

I have demonstrated the process in the following paragraphs by showing the steps of analysis and how “lived experience description” (van Manen, 1990, p.92) was analysed for selected phrases of each transcript to develop themes uncovered from significant words to concepts to sub-themes. It should, therefore, be possible for a reader to audit the decisions I made throughout the analytic process (Koch, 1994).

An example of highlighted statements that seemed necessary to reveal the phenomenon of being a Muslim patient comes from the interview with Akbar. Highlighted statements and phrases which copied and transferred onto computer-spread sheets were shown in bold. An example of his words were:

*It was 6 am that I went to the ward. A nurse welcomed and asked me some questions. She gave me some information about hospital and services I might need in the hospital. Then she showed a room where my bed was there. I walked into the room I felt a bit funny because I have never been in the hospital. However I was not worried at all. There were three beds in the room. I remember that everything was looking clean and tidy. I saw another patient in the bed that was next to my bed. I stayed in my bed until about 12.00 that I intended to do pray. I was confused because I liked to pray before going to theatre. You know, it is not easy if you want to pray in the room that there are some patients, especially in the early morning... Every morning, I was waking up to a predicament when I couldn’t pray out. As*
a Muslim I must pray before sun rising but I couldn’t. Because on one side of my bed was a patient that he didn’t believe God. On the other side was a patient that he was really sick. As a patient, I had to respect them. I decided to pray in the room. For me, the floor did not mean clean even it looked clean. So, I put a newspaper on the floor and just did my pray. There was no suitable place for praying. (Akbar, p. 23, L: 669-681)

Further examples of these individual units from interview transcripts are shown below from two participants, Yasamine and Hussein.

For me, there was no problem before having something to eat. Everything was normal and all services were the same as other patients. After few days, I was allowed to eat. But I realised there was nothing that I would eat because the hospital did not provide halal food. ...I understood, as a Muslim, I was different from others when they come to the hospital. You know what halal means and Muslims should eat halal foods. We can eat non-halal food just in a life threatening situation, but my situation wasn’t life threatening one. Since I live in Australia, I never eat non-halal food at all. (Yasamine, p. 12, L: 340-346)

I want to tell you an interesting story which I had in the hospital. It was happened at the day after my admission in the hospital. In the early morning, I was praying. It was a bit dark and I didn’t turn on the light because other patients in the room were slept. When the nurse entered to the room to do observation, she found I huddled on the floor, mumbling. At first, she [the nurse] thought I had fainted, fallen off the table, and perhaps struck my head. But when he tried to help me up, I became agitated and resisted her help. I couldn’t speak at the time of praying, and she had no idea what I was doing at the time. After finishing my prayer, I explained her that when I pray I can’t to talk to anyone else. (Hussein, p. 52, L: 1547-1552)

Table 6-1 is a sample of the computer-spread sheet that provided tabulated analysis. It would illustrate how the interpretative concepts emerged from the various statements or phrases that were essential in the participants’ stories. Interpretive concepts are written in the third column.
Chapter Six: The Process of Finding Meaning

Table 6-1: Moving from text to concept in thematic analysis process

<table>
<thead>
<tr>
<th>Excerpt</th>
<th>Key words</th>
<th>Concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>You know, it is not easy if you want to pray in the room that there are some patients, especially in the early morning... Every morning, I was waking up to a predicament when I couldn’t pray out. As a Muslim I must pray before sun rising but I couldn’t. Because on one side of my bed was a patient that he didn’t believe God. On the other side was a patient that he was really sick.</td>
<td>waking up to a predicament when I couldn’t pray / I must pray</td>
<td>Obligations of Being a Muslim</td>
</tr>
<tr>
<td>(Akbar, p. 23, L: 669-681)</td>
<td>The hospital did not provide halal food, as a Muslim I was different from others</td>
<td>Inappropriate food</td>
</tr>
<tr>
<td>After few days, I was allowed to eat. But I realised there was nothing that I would eat because the hospital did not provide halal food. ...I understood, as a Muslims, I was different from others when they come to the hospital.</td>
<td></td>
<td>Being different</td>
</tr>
<tr>
<td>(Yasamine, p. 12, L: 340-346)</td>
<td>I was totally alone. More in common with other patients</td>
<td>Loneliness</td>
</tr>
<tr>
<td>I was totally alone. ...As a patient, I had much more in common with other patients than I had differences. But I am a Muslim. ...I didn’t want to be understood only as a patient, who I was not, nor I didn’t want to be seen as a fundamentalist religious person, which I am not. I liked that they [nurses] would know my values and beliefs. I expected they [nurse] knew a bit about Muslims. ...They didn’t spend time to get try to know who I am. That’s why I confined in myself.</td>
<td>They didn’t spend time to get try to know who I am. I confined in myself</td>
<td>Being the same</td>
</tr>
<tr>
<td>(Akbar, p. 22-23, L: 654-674)</td>
<td></td>
<td>Not being understood</td>
</tr>
<tr>
<td>When she [the nurse] entered to the room to do observation, I was praying. She found I huddled on the floor, mumbling. At first, she thought I had fainted, fallen off the table, and perhaps struck my head. But when he tried to help me up, I became agitated and resisted her help. I couldn’t speak at the time of praying, and she had no idea what I was doing at the time</td>
<td></td>
<td>Isolation</td>
</tr>
<tr>
<td>(Hussein, p. 52, L: 1547-1552)</td>
<td>she had no idea what I was doing</td>
<td>Being different</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not being understood</td>
</tr>
</tbody>
</table>

The progression of finding meaning from describing the lived experience to analysing it continued by grouping or aggregating keywords and concepts (going from the parts to the whole) in similar categories (Coffey and Atkinson, 1996) which helped me move from grouped thoughts of the participants to sub-themes and themes. This process was informed by van Manen (1990/1997) and Gadamer (1989), with his ideas of the fusion of horizons and hermeneutics. Therefore other excerpts from the participants’ transcripts were selected and transferred onto the computer-spread sheet, labelled and then grouped together based on similarities of ideas, and analysed together in the same way. Consequently, through the selective approach, I identified and developed themes describing the phenomenon of interest.
An example of how I managed the analytical process is included in the following tables. The tables will illustrate how the core meaning of ‘the challenge of living Islam in the hospital’ which will be discuss in Chapter Seven emerged from two themes, Being-thrown-into-an-un-everyday-world and living-Islam-in-the-un-everyday-world. Table 6-2 demonstrates how the first theme ‘Being-thrown-into-an-un-everyday-world’ developed from two sub-themes of the awareness of self and Being an outsider. Table 6-3 illustrates how the second theme ‘living-Islam-in-the-un-everyday-world’ developed from three sub-themes of Being the same and different, hindrances to Being a Muslim, and adapting-to-un-everyday-world.
Table 6–2: Being-thrown-into-an-un-everyday-world

<table>
<thead>
<tr>
<th>Excerpt</th>
<th>Key words</th>
<th>Concept</th>
<th>Sub-theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have been in Australia since 1996 [seven years before hospitalisation]...I never felt I differed from others people. It seemed perfectly normal to me in the society because everyone has own beliefs and practices in the society. ...it was not until I went to the hospital. I felt different myself from the rest of the patient when I was asking for something different. I understood I differ considerably from those of people who been around me. (Huda, p. 57-58, L: 1707-1718)</td>
<td>I never felt I differed from others people/ until I went to the hospital. in hospital I understood differ considerably</td>
<td>Self-awareness</td>
<td>The awareness of self</td>
</tr>
<tr>
<td>After few days, I was allowed to eat. But I realised there was nothing that I would eat because the hospital did not provide halal food. ...I understood, as a Muslims, I was different from others when they come to the hospital. (Yasamine, p. 12, L: 340-346)</td>
<td>I understood I was different from others</td>
<td>New awareness</td>
<td></td>
</tr>
<tr>
<td>I was leading into a new awareness of my likeness. I just knew that I am belonging to different world. I was trying to tell them [nurses] that I am not like other patients who are like me in very important ways. ...I may not have been able to accept being different before hospitalisation, but I did felt this by the time I was in the hospital. (Sarah, p. 19, L: 565-570)</td>
<td>I was leading into a new awareness of my likeness. I just knew that I am belonging to different world.</td>
<td>Being apart</td>
<td>Being an outsider</td>
</tr>
<tr>
<td>...didn’t have anything in common with other patients and didn’t feel connection to there. (Ali, p. 31, L: 929-930)</td>
<td>didn’t have anything in common/ didn’t feel connection</td>
<td>Loneliness</td>
<td></td>
</tr>
<tr>
<td>I felt less comfortable when I wanted to pray. I liked to hide who I am. (Akbar, p. 23, L: 676-677)</td>
<td>Felt less comfortable/ liked to hide who I am</td>
<td>On the margin</td>
<td></td>
</tr>
<tr>
<td>I was totally alone. (Akbar, p. 22-23, L: 654-674)</td>
<td>Was totally alone</td>
<td>Loneliness</td>
<td></td>
</tr>
<tr>
<td>There was something very different about me that made me to be outside of the other patients. (Hamid, p. 46, L: 1378-1379)</td>
<td>to be outside</td>
<td>Loneliness</td>
<td></td>
</tr>
</tbody>
</table>
Table 6-3: Living-Islam-in-the-un-everyday-world

<table>
<thead>
<tr>
<th>Excerpt</th>
<th>Key words</th>
<th>Concept</th>
<th>Sub-theme</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>I know we [patients] are all the same. We needed to be there and looked after by them [health professionals].</em></td>
<td><em>We are all the same</em></td>
<td><em>Similarities</em></td>
<td><em>Being the same and different</em></td>
</tr>
<tr>
<td><em>(Fariba, p. 5, L: 55-137)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>But our beliefs and practices are different from the beliefs of healthcare professionals.</em></td>
<td><em>beliefs and practices are different</em></td>
<td><em>Differences</em></td>
<td></td>
</tr>
<tr>
<td><em>(Fariba, p. 5, L: 55-138)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Religion has a major impact in the daily life of Muslims. When thinking of the needs of Muslim patients, they need consider Islamic rules.</em></td>
<td>…needs of Muslim patients, …need consider Islamic rules</td>
<td><em>Different needs</em></td>
<td></td>
</tr>
<tr>
<td><em>(Fariba, p. 4, L: 102-103)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>We [Muslims] are not allowed to eat the pig. Allah has told us that we cannot eat this animal.</em></td>
<td><em>not allowed to eat the pig</em></td>
<td><em>Fixed care</em></td>
<td><em>Hindrances to Being a Muslim</em></td>
</tr>
<tr>
<td><em>(Ali, p. 32, L: 950-956)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>For [some] nurses, all of us were patient. No matter where we were from... what we need. They see just our medical problem.</em></td>
<td><em>all of us were patient</em></td>
<td><em>Fixed care</em></td>
<td></td>
</tr>
<tr>
<td><em>(Fatima, p. 41-42, L: 1211-1236)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>I looked after a Muslim patient before. I know you eat halal. But I said I don’t care if the food isn’t halal.</em></td>
<td><em>don’t care if the food isn’t halal</em></td>
<td><em>Diversity among Muslims</em></td>
<td></td>
</tr>
<tr>
<td><em>(Huda, p. 57, L: 1681-1684)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>I asked my family to provide meal that I would eat it.</em></td>
<td><em>my family to provide meal</em></td>
<td><em>Looking for alternatives</em></td>
<td></td>
</tr>
<tr>
<td><em>(Marzieh, p. 8, L: 215-226)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Well, when I went to hospital, there was no female doctor and my gynaecological exam was done by a male doctor. I wanted to refuse but my condition was an urgent one.</em></td>
<td><em>my condition was an urgent</em></td>
<td><em>Need to adapt</em></td>
<td></td>
</tr>
<tr>
<td><em>(Marzieh, p. 6, L: 175)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The following table summarises these themes and sub-themes, which will discuss in Chapter Seven.

Table 6-4: Themes and sub-themes

<table>
<thead>
<tr>
<th>Sub-themes</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>The awareness of self</td>
<td>Being-thrown-into-an-un-everyday-world</td>
</tr>
<tr>
<td>Being an outsider</td>
<td></td>
</tr>
<tr>
<td>Being the same and different</td>
<td></td>
</tr>
<tr>
<td>Hindrances to Being a Muslim</td>
<td>Living-Islam-in-the-un-everyday-world</td>
</tr>
<tr>
<td>Adapting-to-the-un-everyday-world</td>
<td></td>
</tr>
</tbody>
</table>

6.4.3. Detailed approach

Using the “detailed reading approach” as suggested by van Manen (1990, p. 93), the researcher is required to look at every transcribed sentence or cluster of sentences and ask, ‘What is this person saying and how can these ideas be understood in meaningful ways or be encapsulated to reflected their major concerns? I searched through each transcript and assigned key words and concepts to each sentence or cluster of sentences containing a new idea.

In using these three approaches I was able to allow projections about the whole to surface and to discriminate among them. The necessity to circle back and forth from the original texts to the data sets was found many times while I worked with the data sets. In doing this, I moved things around both on paper and in my head and became increasingly confident that dominant concepts were beginning to surface. At times I changed my mind about my reflections, feeling that the words I selected to exemplify a concept did not portray the essence of what a participant was telling me. So, I again returned to the text to explore the context in which the discussion took place. Ultimately, these concepts and salient items fused with my own pre-understandings and allowed the phenomenon of being a Muslim in an Australian hospital for these participants to become clear.
6.5. Interpretive activities

At the end of the process of finding meaning, the immediate and embodied horizons of the participants were further enlarged and joined with my horizon of understanding (Gadamer, 1989). As this study was underpinned by the philosophy of hermeneutics, it is worth revisiting some of the ideas of hermeneutics and how they were applied to the interpretation process. This thesis deals with the lived experience of thirteen Muslim patients who had been in an Australian hospital and trying to make meaning of the lived experiences as described by them. The results of my interpretation are a fusion of horizons (Gadamer, 1989). This horizon of mine, therefore, was created out of this inter-subjectivity and culminated in my understandings of what it was like to live in-the-world-as-a-Muslim-patient-in-non-Islamic-hospitals. Therefore my ideas, beliefs and understandings merged with those of the participants to create a new perception of reality, which is described here.

In applying philosophical hermeneutics and beginning the process of interpretation, I immersed myself in the data and became part of it, seeking to understand what it was to be a Muslim patient in a non-Islamic hospital. The facts uncovered were not separate from their meaning; neither was my perception, in the end, separate from the participants’ stories in the text. What is here now in this interpretation phase of the thesis is my meaning, my story as researcher, merged with the stories from the participants interviewed.

I used some themes to discern the Muslim patient experience. Whilst I acknowledge that it is not the definitive interpretation, I believed it is a reasoned and coherent account of the phenomenon under study. Data analysis occurred within an interpretive horizon that had already turned to the phenomenon of being Muslim patient through my appraisal of what was understood about this phenomenon. I developed my horizon of understanding, the themes, through further reflection and interaction with the parts, other textual content, and the whole of the data. I produced interpretations of the
phenomenon of being a Muslim patient that is constituted in the body of this thesis. Chapter Seven describes the themes in detail.

6.6. Summary

In this chapter, I described the process of meaning making (data analysis). Throughout this chapter, I demonstrated clearly that the methods used for interpreting the data were congruent with the philosophical underpinnings of hermeneutic phenomenology. By adhering to this method, I was allowed considerable flexibility to uncover the meaning participants attributed to this lived experience of the phenomenon that the researcher was seeking to understand. The next chapter, Chapter Seven, will present interpretation of themes and sub-themes which emerged from the process of data analysis.
CHAPTER SEVEN
UNDERSTANDING THE EXPERIENCE OF
BEING A MUSLIM PATIENT

7.0. Introduction

This chapter presents the themes that explicate the interpretive dimensions of the meaning of Being a Muslim patient in a non-Islamic hospital. This interpretation and meaning emerged from a deep connection with the content of the various dialogues held with thirteen Muslims who have lived this experience. The understanding of the phenomenon presented in this study, therefore, is an interpretation of the substance contained in the conversations held with the participants and the text formed by these dialogues interlaced with the researcher’s comprehension.

In this chapter, the focus is on themes that emerged from the participants’ stories and underpin the lived experiences of Muslim patients in a non-Islamic hospital and expanded my understanding of the phenomenon. The themes were evident irrespective of the nature of participants’ illness. The nature of their illness was not generally foregrounded in this study.
In order to present my interpretation of the experience of Being a Muslim patient in a useful way, I have deliberately arranged common patterns of understanding shared by participants thematically. The interpretation is presented and in a pattern that moves from the expression of Being a Muslim patient in a non-Islamic hospital to the themes, to the sub-themes, and their constitutive concepts. While this may suggest an interpretation that is linear this is not the case. As described in Chapter Six, the interpretation was a process of considering the parts that constitute the experience and from these constructing the whole, which is the phenomenon of interest. Concepts are identified which then leaded to the emergence of sub-themes, then themes and the core meaning of the phenomenon that is ‘the challenge living Islam in the hospital’. The process is one of moving from the parts to the whole then considering the parts again in light of emerging themes. The journey was one where no element is finalised without considering of others that constituted the whole or in deeded the whole itself. The hermeneutic circle has no beginning or end and yet the presentation of the interpretation must have a beginning. Conventionally many phenomenological studies present the interpretation beginning with the smallest elements of the phenomenon and building to the core meaning of phenomenon. Again this is suggestive of a linear process of interpretation. I have not followed this convention and begin with a brief description of the whole and then proceed to parts from which the core meaning emerged and then conclude by returning to whole.

7.1. The Challenge of Living Islam in Hospital

Over the past two years of reflecting upon and dialoguing with each participant’s stories, I have come to understand the lived experience of Being a Muslim patient in a non-Islamic hospital could be characterised by the expression: the challenge of living Islam in hospital, as Sarah said to me:

…it was challenging being the only Muslim patient in the hospital. (Sarah, p. 16, L: 461)
I found ‘the challenge of living Islam in hospital’ to be an important representation of the participants’ stories. Although the participants were pleased and impressed with the delivery of high quality services, the experience of the majority of the participants was one of challenge. The experience was one of being drawn to consider firstly Being a Muslim and then understanding that to live Islam in hospital was a challenge that had to be met in a way that was not evident in their everyday life. For participants, ‘the challenge of living Islam in hospital’ essentially refers to managing aspects of their daily life in circumstances where barriers and hindrances need to be overcome. The examples of such challenges are:

Before going to the hospital, it was my impression that everything in my life would be normal, but it wasn’t as I expected. I am saying this from an Islamic perspective. (Fariba, p. 2, L: 51-53)

Huda said:

*I think everything was perfect; it just my problem that such perfect services was not fit for me.* (Huda, p. 56, L: 1691-1693)

Ali also had this to say:

*In one word, being a Muslim patient [in a non-Islamic hospital] is hard; very hard. I’ve experienced it.* (Ali, p. 35, L: 1047-1049)

From the outset, I do wish to acknowledge that this understanding of ‘the challenge of living Islam in hospital’ is a theoretical abstraction of the participants’ experience which at first appears somewhat antithetical to the general methodological orientation of this thesis. However, by gathering all the fragments of the meaning that I have made about the participants’ experiences into a meaningful whole I succeed, as (Shotter, 1995) reasons in placing the ‘particular’ in the ‘general’. This theoretical abstraction, therefore, is not intended to be realised or discussed as a rule of practice about Muslim patients’ experiences. Instead, the concept of ‘the challenge of living Islam in hospital’ is intended here to act as a central, coherent idea from where future arguments to support changes in practice can be developed and advanced.
As described in Chapter Four, interviewing the study participants and data analysis using Gadamer’s (Armstrong, 2004) hermeneutic phenomenological approach resulted in the fusion of horizons of the participants’ lived experiences. In this interpretive process, Islamic philosophy, theories of multiculturalism, culturally competence care notions, and my pre-understanding of Islam were four crucial and basic concepts which influenced the interpretation of the texts and understanding of the phenomenon and the identification the themes.

The themes, **Being-thrown-into-an-un-everyday-world** and **living-Islam-in-the-un-everyday-world**, emerged from the interpretation process. These themes and their constituent sub-themes developed the concept of ‘the challenge of living Islam in hospital’ from the texts which were verbatim transcripts of the participants’ interview through the interpretation process.

Together the themes form, in van Manen’s words, “an intricate unity” (van Manen, 1990, p. 105) that draws together the experience of Being a Muslim patient. There is no intention to weight or give more importance to one theme or another. In each case, the themes contribute to the complete picture of the lived experiences of the participants in an Australian hospital. The themes of understanding of are summarised below.

- **Being-thrown-into-an-un-everyday-world** means the discontinuity from the everyday world of the participants that drew them to consider and become overtly aware of their self. The notion of Being thrown into a different world explores the participants experience in relation to their perception and awareness of being different from others that became manifest during their hospitalisation. Being thrown into a different world is the experience of living life from another point of view that may be a contemplative or introspective experience. Being thrown into a different world, therefore, relates to the process of identification and differentiation of the cultural diversity of the participants in this study.

- **Living-Islam-in-the-un-everyday-world** relates to the meeting of two different cultures. This theme comprises the recognition that to be a Muslim there are specific needs, customs, practices, and expectations that
must be realised. There is also the recognition that illness must be overcome and that high quality care must be provided to achieve this. There is a duality here that results in a tension where participants perceived barriers or hindrances to living Islam in a world removed from the everyday. The challenge is then to adapt and work to develop mechanisms to overcome these hindrances and realise the goal of living Islam.

It might be valuable to remind the reader that although the themes in this study are presented and examined as individual components they are interrelated and one theme always calls forth the other. Thus, whilst these themes represent an artificial separation of components of Being a Muslim patient, as perceived by the participants, they occur simultaneously and are separated purely to provide clarity for the reader. It is hoped that throughout the reading of the interpretation, the relevance of each theme for the other will become obvious, as they are all components of the one experience.

7.2. Being-thrown-into-an-un-everyday-world

In the process of interpreting the text, it became obvious that one of the first issues experienced by all the participants was the perception of Being-thrown-into-an-un-everyday-world. As Huda said to me:

*I felt that I was in a different world.* (Huda, p. 56, L: 1658)

For participants, the transition from their own home to hospital was a discontinuation of the ordinary and the everyday. The world they found themselves in was unfamiliar and contrasted with ‘their’ world. As Sarah revealed in the following excerpt:

*I felt, I was in a world that is unknown. It was like going to another planet, all that is familiar and conforming is suddenly gone.* (Sarah, p. 16, L: 477-478)

Hamid also related:
My admission in the hospital was inevitable. It made me felt a bit funny. Like, I felt separate from the world. (Hamid, p. 46, L: 1360-1361)

The stories of Sarah and Hamid describe how they felt as if they were uprooted from their everyday lives and felt cut off and disconnected from their normal environment and way of life and catapulted or thrown into the unfamiliar world of non-Islamic hospital. The consequence of Being-thrown-into-the-un-everyday-world was that participants are being drawn to consider their circumstance in a way that does not occur in their everyday world.

The participants felt Being-thrown-into-an-un-everyday-world was the constant awareness and critical thinking of self. Critical thinking requires an “awareness of interpersonal dynamics” (Uchem, 2001, p. 19). Consequently two interwoven sub-themes emerged, the awareness of self and Being an outsider and these are described in the following section.

7.2.1. The awareness of self

The sub-theme, the awareness of self, was used to articulate the feeling of having to consider your self because of being removed from the everyday. Fariba gave the following account:

The whole thing was like being taken from your own world and placed somewhere else. (Fariba, 5, L: 137-138)

This occurred to her from the moment she stepped into the hospital. As she added that:

When I went to the hospital, I felt discomfort which made me feel strongly that I was stranger. (Fariba, p. 1, L: 18-19)

Yasamine also echoed:

Everyone seemed to know each other and I didn’t know anyone. (Yasamine, p. 12, L: 348-349)

Fatima also communicated the permanence of this awareness:
I was different from other patients and that I always would be. (Fatima, p. 42, L: 1257-1259)

Participants explained how their admission to an Australian hospital was not a gradual situation for which they had warning or could prepare for. Instead, all participants spoke at great length and in vivid detail about how their admission developed a feeling that they found themselves within an unknown world which was so different from their normal life or ‘everyday’ world. Hussein, for example, acknowledged:

For me, nothing was normal or familiar when I went to the hospital. (Hussein, p. 51, 1530)

Most of the participants in my study perceived that as they go through everyday life they are not overtly conscious of the differences they had to the majority of the Australian community. Everyday life was not one where reflection on self and an examination of how one differs from others is apparent. Being different is only considered when something conspicuous is noted, leading to an overt contemplation of self. The presence of such conspicuous factors occurred as a consequence of hospitalisation, resulting in an awareness of the participants to think about themselves, the environment they engaged with, and the people who were around them.

An awareness of self is expressed by Marzieh who referred to the ‘before and after’ of her experience of being admitted to the hospital. Marzieh found that her life did not continue on as before when she had been in the hospital. Marzieh referred to before as her normal way of life, which discontinued when she was in the hospital and described how her hospitalisation developed an awareness of being in a different world:

Before I went there [the hospital], life was okay, not too bad really when I was in the society. Like everyone I just go about my normal business. And then... I remember walking to the ward and thinking, this is not the place I’m used to living there. It was totally different place. (Marzieh, p. 7, L: 199-209)

The ‘before’ was prior to her hospitalisation and referred to the normal life. But following admission in the hospital, her normal way of Being-in-the-world was disrupted and she was unable to continue with her life as before. This perception
plunged the participants in this study into a new awareness, which facilitated a shift in thinking more critically about differences and recognising how their religion makes them different from other patients. Sarah’s account is a typical example. She admitted:

I was leading into a new awareness of my likeness. I just knew that I am belonging to different world. I was trying to tell them [nurses] that I am not like other patients who are like me in very important ways. ...I may not have been able to accept being different before hospitalisation, but I did felt this by the time I was in the hospital. (Sarah, p. 19, L: 565-570)

Huda also explained:

I have been in Australia since 1996 [seven years before hospitalisation]...I never felt I differed from others people. It seemed perfectly normal to me in the society because everyone has own beliefs and practices in the society. ...it was not until I went to the hospital. I felt different myself from the rest of the patient when I was asking for something different. At that time, I was thinking that I differ considerably from those of people who been around me. (Huda, p. 57-58, L: 1707-1718)

Hospitalisation, was conspicuous and brought an awareness of self and a feeling of being in a different world with little resemblance to the normal, familiar and everyday world. It was accompanied by feelings of which participants perceived themselves consistently different from other patients primarily because of their religious affiliation.

The process of this overt awareness occurred with different triggers. For instance, a different dietary requirement can be one of the conspicuous issues confronting the participants while in the hospital. For some of the participants, this process was slow and vague while for others it was sudden and more challenging. Yalda said to me:

It was lunch time that I went to the hospital. I remember I was really hungry. She [meal distribution staff] brought a food which had a mix of beef. When I asked whether the food was halal? She did not understand what I was asking. I was really surprised. ... At that time I got conscious about the fact that Muslims differ from the general population (Yalda, p. 62, L: 1846-1855).

Unlike Yalda, who experienced a sudden challenge in terms of dietary requirements in the hospital, Yasamine faced the challenge of dietary requirements a few days after her admission. She recounted:
After few days, I was allowed to eat. But I realised there was nothing that I would eat because the hospital did not provide halal food. ...I understood, as a Muslims, I was different from others when they come to the hospital.  
(Yasamine, p. 12, L: 340-346)

It was not always a single issue that triggered this awareness. Ali recalls:

Everything was going to be hard. First, I found the hospital food was not halal, then no any appropriate place for praying and...I knew I wasn’t like them. It was very uncomfortable to stay in the hospital, so I liked to be discharged very soon. (Ali, p. 33, L: 981-984)

This heightened awareness of self, triggered by admission to hospital was not isolated to being away from the familiar, from the everyday. Returning to participants’ stories I found that the outcome of self-awareness could be to reinforce a sense of ‘otherness’. This sense of otherness stimulated in participants a range of feelings that could be encapsulated as Being an outsider in spite of an apparent desire for inclusiveness. The next section details the theme ‘Being an outsider’.

### 7.2.2. Being an outsider

The sub-theme, Being an outsider, was for the participants a consequence of self-awareness arising from Being-thrown-into-an-un-everyday-world. Being an outsider came to me as I engaged in a dialogue with the participants’ stories and fused my horizons of understanding of the phenomenon. It was the self awareness which induced a feeling of separation from other people when in the hospital. As pointed out before, there were consistent experiences of self awareness in terms of Being different across the participants’ stories. Following this initial perception, the perception of these participants developed into a sense of Being on the outside, on the fringe or the margin and ultimately not belonging. It should be noted again here that this is an account of the experience of Being an outsider for the participants in this study and not necessarily for all other Muslim patients in non-Islamic hospitals.

Although most of the participants had been resident in Australia for a long time, the hospital was a different place from the society that they were used to and caused
participants to feel they did not belong. The experience came across as being extremely emotional and salient in the lives of participants. From the participants’ stories, it was clear that being an outsider was for many somewhat of a silent challenge for the participants. This silent challenge was central to the challenge of living Islam in non-Islamic hospitals and the participants in my study responded to this challenge at the interpersonal level.

Hussein’s feeling of being an outsider was expressed as a cognitive loneliness during his hospitalisation. This reflected an interpersonal deficit that existed as a result of cultural differences between Islamic culture and dominant Australian culture. He recounted in his story that:

*I was confronted by a situation which I felt I’m alone…I preferred to sit in my bed.* (Hussein, p. 53, L: 1569-1574)

Cognitive loneliness is based on cognitive processes such as self-evaluation, self-perception, and social comparison (Weiss, 1973). The following, Akbar’s story, is an example, which explicates how the experience of self-awareness and the perception of being an outsider were accompanied by a growing and strong feeling of Being alone during his hospitalisation:

*I was totally alone. …As a patient, I had much more in common with other patients than I had differences. But I am a Muslim. …I didn’t want to be understood only as a patient, who I was not, nor I didn’t want to be seen as a fundamentalist religious person, which I am not. I liked that they [nurses] would know my values and beliefs. I expected they knew a bit about Muslims. …They didn’t spend time to get try to know who I am. That’s why I confided in myself.* (Akbar, p. 22-23, L: 654-674)

The concept of Being alone was expressed by the participants in a number of ways but in particular was expressed as a desire to de-emphasise differences with others. Sarah expressed this as:

*I was the only Muslim patient there. …I wanted to keep quiet and not say anything.* (Sarah, p. 16-18, L: 461-533)

A further example of the silent challenge of participants’ response to Being an outsider is found in Akbar’s story. He related that:
I felt less comfortable and alone when I wanted to pray. I liked to hide who I am. (Akbar, p. 23, L: 676-677)

Fatima’s story is another example of silent challenge. She related in her story that:

I liked to tell them, my religion always comes first. You can say I’m old fashioned. That’s the way my parents raised me but I’m not selfish. (Fatima, p. 43, L: 1266-1267)

Yasamine also recounted such challenge in her story. She stated her discomfort with being different was accompanied by feeling of loneliness as she related:

...there was a lot of frustration. I felt extremely lonely. (Yasamine, p. 14, L: 418-420)

The participants identified the inaccessibility of appropriate services was closely associated with a strong experience of loneliness which extended even into the spatial experiences of these participants. In the following extracts Hussein explained how the inaccessibility of appropriate services led him to feeling loneliness. Hussein made boundaries between himself and other patients and related that:

I prayed in the room. Imagine how hard would be when you are going to pray in the early morning when everyone was sleep. I felt very shy when I saw he [the patient] was gazing at me to see what I was doing. I thought he was telling himself how crazy I am. ...It was annoying and separates me from others. (Hussein, p. 53, L: 1585-1590)

The perception of Being an outsider contributed to their feeling of separation. Sharkira discussed her experience of Being a Muslim patient in an Australian hospital. She expressed in her story that:

Everything was different. You can be the same as everyone when you walk on the street. But there [in the hospital] I don’t believe I was the same as other people. (Shakira, p. 26-27, L: 780-782)

Another participant said to me:

There was something very different about me that made me to not belong there. (Hamid, p. 46, L: 1378-1379)
Most of the participants in this study experienced not belonging in very constant ways. Ali, for example, felt he was different from others and there was nothing in common between him and other patients. As he related:

*I didn’t have anything in common with other patients and didn’t feel connection to there.* (Ali, p. 31, L: 929-930)

The following excerpts from Yalda and Fatima express the same feeling, as Yalda recounted:

*I guess I felt like I didn’t belong because I didn’t like the same things they did.* (Yalda, p. 61, L: 1826)

And Fatima said in his story that:

*My behaviour and the way I viewed life and how I conducted myself caused I felt separated from others, completely different.* (Fatima, p. 44, L: 1310-1311)

Yasamine echoed such feeling when describing her experience in the theatre’s waiting room:

*From that time, I had felt unaided... [pause] and felt I was separated from everyone else.* (Yasamine, p. 14, L: 392)

Separation and isolation gave rise to feeling of helplessness for the participants. In the following excerpt, Shakira narrated how she experienced the feeling of helplessness when there was an inability to treat her baby in Islamic way.

*I liked someone would help us to say Shahada [the declaration of faith; It is recommended, if at all possible, for a Muslim's last words to be the declaration of faith: ‘I bear witness that there is no god but Allah’] and recite Quran when my baby passed away. I liked they knew how to prepare and shroud my dead baby in Islamic rites. But nobody... [pause] I felt really lonely and helpless. You think it wasn’t hard that my husband should do these?* (Shakira, p. 29-30, L: 865-871)

In describing the feeling of helplessness, Fatima, who believed her religious affiliation contributed to her isolation pointed out that:
...It’s frustrating. I believe that no matter what religion, all are human beings. We are different, but it is the job of the nurses to find out how treats patients and manages such differences. …If one is a Muslim patient, you may have no chance like other people to get what you like. (Fatima, p. 41-42, L: 1229-1236)

This feeling of being an outsider was at times very polarising. The following extract of Ali’s story is a typical example:

Of course it is their hospital and we are not a part of... I’m not complaining, but everything is for them, for their needs. No one asked the reason why my family was brining food for me. I think that they [health professionals] view our requests and needs as demand an imposition upon their workloads. (Ali, p. 34, L: 1015-1020)

The key word is in this excerpt is ‘them’. As part of Australian society, Ali believed that his needs have not been reflected in his care plan. Therefore the consumption of halal food served to differentiate between ‘them’ and ‘us’, as voiced by Ali in this study.

Being an outsider serves to express the participants perceived feeling of subordination in the experience of Muslim patients during their hospitalisation in a non-Islamic hospital. A consequence of feeling an outsider is the associated feeling of powerlessness. Sarah’s story discloses how she felt:

I had to put on my headscarf all the time. It was really uncomfortable. I prefer to be in a private room. But it was difficult to request it and I didn’t feel I had any power to ask that. I don’t know whether it was right or not anyway. ...I wanted to... [pause] I just had to ignore it. (Sarah, p. 17, L: 491-501)

The feeling of loneliness was particularly voiced by those had shorter stays in the hospital; however this did not mean that this experience was persistent. Marzieh and Shakira, for example, who had long admissions, spoke of their experience of loneliness in first few days after admission to the hospital:

When I went to the hospital I felt nobody see me... Well I was for a long time in the hospital. I knew all nurses and doctors. ...Some times I was talking to them about my religion, my lifestyle, and everything I liked. (Marzieh, p. 6-9, L: 177-268)
Shakira also echoed:

*You don’t necessarily feel... I think every patient may feel friendless in the first few days. If you had been in the hospital for a long time, then you would feel comfortable there, like me.* (Shakira, p.26-28, L: 780-829)

The intensity of Being an outsider began to decrease if the individual could successfully negotiate the attempt to belong. In such cases, the experience of Being an outsider faded and became less central to them. Marzieh, in reflecting on her experience of being on the outside said:

*I think we have to explain our whole life to them. In every new situation, you don’t necessary belong... If you’ve been in the hospital for a long time, then you belong and you feel comfortable there but if you don’t then you kind of have to get to that point.* (Marzieh, p. 9-10, L: 268-27)

Being an outsider is a complex phenomenon, often characterised by unpleasantness, anxiety and even pain (Uchem, 2001). The experience of Being an outsider for the participants was characterised by feelings of loneliness, helplessness, powerlessness, being separate and not belonging. The two sub-themes of ‘self-awareness’ and ‘Being an outsider’ are both an expression and consequence of the participants Being thrown into the un-everyday world of a non Islamic hospital. Removed from the everyday the participants are drawn to reflect and assess their situation. This aspect of the participants experience in itself is significant but it should not be viewed in isolation. It can be viewed as a starting point for the challenge of living Islam in hospital, as a part of the whole, but there is risk in underestimating the interrelation with the second theme, ‘living-Islam-in-the-un-everyday-world’.

### 7.3. Living-Islam-in-the-un-everyday-world

*Living-Islam-in-the-un-everyday-world* is the next theme to be discussed. I came to understand the centrality of the role of Islamic tradition as a constant state of Being that each participant lives in her/his experience of hospitalisation in a non-Islamic hospital. Having been thrown into a world that compels the participants to consider the
awareness they have of themselves and that Being Muslim brings a sense of Being an outsider then leads the participants to further meanings of this experience.

Living-Islam-in-the-un-everyday-world, in the context of this study, refers to the difficulties encountered by the participants attempting to adhere to the principles of their faith in the culturally Western-based environment of the hospital and describes how the participants managed their daily life during hospitalisation. The elements of this aspect of the ‘challenge’ are to consider what it is to be a patient and Muslim, to experience barriers or hindrances to Being Muslim and finally the experience of working to meet the challenge of living Islam in the hospital.

Sarah reflected on her hospitalisation and recounted:

>You know, you are a patient in the hospital, whatever, you know what I’m saying. You are sick and you have to stay in the hospital, that’s your new place. But in your new place, there is no much thing as your place (Sarah, p. 20, L: 587-590).

In the theme, ‘living-Islam-in-the-un-everyday-world’, the three sub-themes, Being the same and different, hindrance to Being a Muslim, and adapting-to-the-un-everyday-world, are described.

### 7.3.1. Being the same and different

The sub-theme, Being the same and different, is where participants spoke about being in an Australian hospital with the focus on having a variety of needs to be met. On the one hand they were aware of their need to achieve a good outcome with regard to their health. Their perception was that this was a need common to all patients and an aspect of their experience that was the ‘same’ as others. On the other hand they also had the need to live Islam, that is to be Muslim and they recognised this as a point of difference.

It was apparent from the participants’ stories that the experience of Being the same and different was persistently voiced by most of the participants in this study. Being the same and different was a theme that would be challenging for both patients and health
professionals and can be traced to a tension between cultures. The stories of participants explicated that there was a tension arising from Being the same and different during their hospitalisation. This tension was not simply about competing needs and the tendency for certain cultural needs to be ignored or to be given a lower priority, although there were instances where this occurred. The situation was far more complex than this.

Clearly for many of the participants there was recognition that they were patients, the same as others within a system that was designed to provide health care. The participants however also recognised that they were different and that central to this difference was their need to be Muslim. They believed that Being Muslim was to have values and beliefs which were not shared with the dominant culture. The following excerpts from Fariba and Habib help to illustrate this tension between being the same and different. Fariba recounted:

*As a Muslim woman, I couldn’t accept a male nurse to look after me if a female nurse can do. …When I was crying, he [the male nurse] supposed I was in pain. He frequently asked me for painkiller. I wished I would tell him I liked that a female nurse to look after me. …I know we are all the same. But our beliefs and practices are different from the beliefs of healthcare professionals. Still I have difficulties in understanding and accepting this.* (Fariba, p. 2-5, L: 55-139)

And Habib related that:

*I support the idea that every individual has the right to choose what he or she wants. However it is possible that one person’s beliefs and values may conflict with another’s. It is when belief is turned into action like providing care for Muslims by non-Muslims.* (Habib, p. 40, L: 1189-1195)

Although each participant spoke about different things, their stories were consistent enough to affirm that they shared a common experience of the differences between the Islamic lifestyle and Australian dominant lifestyle during their hospitalisation. The participants of this study emphasised that Australian hospitals provided high quality care particularly in comparison with their previous experience in non-Australian hospitals. However they expressed how difficult was it to deal with and accept such
high quality care when at times what was considered to be basic needs were not being met:

*I must say, I was impressed with the hospital staffs and services. It was great. ...For me it was important to be a Muslim woman.* (Marzieh, p. 6, L: 165-169)

An important aspect of this sub-theme is the centrality of religion and most participants wanted to express this as a major point of difference. Yalda, for example, said that:

*I’ll tell you the story of being a Muslim patient in a non-Islamic hospital. For me as a Muslim, Islam is the way of life and all aspects of my life view within the context of religion. It is different from religion as understood in the West.* (Yalda, p. 61, L: 1808-1813)

Fariba also added:

*Religion has a major impact in the daily life of Muslims. When thinking of the needs of Muslim patients, they need consider Islamic rules.* (Fariba, p. 4, L: 102-103)

A few sentences spoken by Hussein and Sarah were sufficient to understand how the religious dimension of existence was the most important part of their lives.

*I practically live in a religious world.* (Hussein, p. 51, L: 1506)

And the following sentence was in Sarah’s story:

*Religion plays a big role in my family.* (Sarah, p. 18, L: 533)

The quote from Shakira is typical of many who expressed the significance of religion in Muslims’ life:

*My religion is not something set apart from my life. In fact, my religion is a system that touches on all facets of my life. Well, you know, it is something that permeates all aspects of my life. ...I really wanted my dead baby to be treated, washed and wrapped in Islamic way.* (Shakira, p. 29, L: 851-854)

The participants wanted to reinforce that to be Muslim a range of behaviours, practices and observances were required. These would relate to dietary requirements, modesty,
prayer and burial issues. Their stories disclosed that these types of diverse needs were demanded by all of them and were the reality of Being a Muslim and reflect the phenomenon of Being the same and different. The need to undertake these observances was in most cases not considered optional and therefore represented a basic need for the participants.

Concerns about dietary requirements in particular were recounted by most of the participants. Obviously food preferences vary widely from culture to culture. However, for some faith traditions including Islam, food and the rituals surrounding its preparation and consumption are the cornerstone upon which religious identity is based. As Hussein stated:

\[\text{We [Muslims] believe that the body is the temple of God and a halal diet contributes to care of the body temple and a healthy lifestyle. (Hussein, p. 52-53, L: 1560-1561)}\]

In this study, Ali talked about foods that Muslims were allowed to eat and pointed out:

\[\text{Muslims are not allowed to eat the pig. Allah has told us that we cannot eat this animal. Also we are not allowed to eat the part of any animal that is not killed in the way that it has been asked us. We are not allowed to drink alcohol or consume or take any intoxicants like drugs (Ali, p. 32, L: 950-956)}\]

As a general rule, Muslims are allowed to consume all foods such as grains, vegetables, fish and meat, except those that are explicitly prohibited in Islam. Prohibited foods are very few and include: alcoholic drinks such as beer and wine; pig meat and by-products of the pig such as pig fat; meat of an animal that has died of natural causes or as a result of strangling or beating; and blood that is in liquid, drinkable form (Henley and Schott, 2003; Rippin, 2006).

It should be noted however that although concern for appropriately prepared food was common to many, not all participants felt as strongly about this issue. For instance, Fariba related that she was in great need to know the halal status of food products in hospital because it is based on strict Islamic dietary requirements, she believed:
Islam provides guidance for dietary laws. ...I don’t mind where I’m [she referred to the hospital where she was obliged to be there because of her health condition]. I follow the Islamic dietary requirement. (Fariba, p. 2, L: 52-59)

Huda on the other hand said:

*I used to eat non-halal foods* (Huda, p. 56, L: 1683)

She also related that:

*She [the nurse] told me, “I looked after a Muslim patient before. I know you eat halal”. But I said I don’t care if the food isn’t halal.* (Huda, p. 57, L: 1681-1682)

Huda’s story indicates that although general information on food and the Muslim patient is essential for healthcare professionals, it is important to avoid assumptions and to gather information from each individual as to their specific needs.

Issues with regard to modesty particularly in relation to gender were another common concern that ran through all the participants’ stories. Participants spoke of the need to recognise the issue of gender as an important issue in caring for Muslims and they liked to be looked after by staff of the same gender, especially in relation to gynaecological problems. Huda, for example, who does not wear a headscarf and considers herself a thoroughly modern Muslim woman recounted:

*I need to feel at ease with my doctor and people who look after me.* (Huda, p. 56, L: 1673)

And she added:

*I am more comfortable going to a female doctor.* (Huda, p. 56, L: 1677)

I was thoughtful that Huda could have been speaking for tens of thousands non-Muslim women in Australian hospitals. However, for many Muslim women there is a strong reluctance to go to health care providers who are not the same gender. Understandably, for Muslim patients this can lead to problems for hospitals in finding enough female physicians, particularly for intimate procedures. As Shakira said to me that:
Well, when I went to hospital, there was no female doctor and my gynaecological exam was done by a male doctor. (Marzieh, p. 6, L: 173)

She recalled the dilemma of facing a male doctor when she knew there was no female doctor and she felt uncomfortable:

I didn’t like [pause] ...I wanted to refuse but my condition was an urgent one. ...I knew it was Okay in such situation. (Marzieh, p. 6, L: 174-178)

Fariba also told me that:

…it was unacceptable. I was a woman, and I should not be looked after by him [the male nurse] except in emergency situation. But it was not. (Fariba, p. 2, L: 59-60)

She explained it has been advised that Muslim patients are allowed to be cared by health professionals from the opposite gender but only when it becomes difficult to have a health professional of the same gender.

Modesty demands that women be fully clothed when they are in presence of a man and this was articulated in the participants’ stories. In general, both men and women are expected to dress in a way that is simple, modest and dignified. Covering the face is not and has never been universal in the Muslim world. Traditions of female dress found in some Muslim countries are often expression of local custom rather than religious principle (Henley and Schott, 2003; Rippin, 2006).

All women participants in this study, except one, indicated challenges that they faced because of their hijab. Observing the hijab from outside, it is impossible to see what it hides. Fatima, for example, expressed anger when one of the patients questioned her about her Hijab. She related:

She [the patient] asked ‘Why I wear scarf? Are you bald?’ I didn’t like to explain it is my belief. (Fatima, p. 43, L: 1289-1290)

Modesty demands made Yasamine uncomfortable as she recalled:

Wearing hospital gown made me uncomfortable. I needed to cover my body again and again. I had wrapped a towel on my head to cover my hair. And I
wrapped a sheet around my shoulders. In waiting room, I realised that my cover was not the same as them. ...At that time, I just closed my eyes and asked myself that am I bothering the people sitting in the room? What is the acceptable was of wearing in theatre? Is it Okay if I warp my body in the sheet? (Yasamine, p. 12-13, L: 354-364)

Fariba and Yalda echoed modesty demands in their stories and said they had to put on their headscarf on all the time when they were in a shared room.

I had headscarf on even I was sleep. (Fariba, p. 4, L: 113)

And:

My headscarf should be always available. (Yalda, p. 64, 1919)

Muslim people find spirituality through religion. However many authors recommend the difference between spirituality and religion should be clarified and they advocate a universal, broad-based definition of spirituality that encompasses religious and non-religious perspectives (Carigie and Hobbs, 1999; Thomlinson, 2002). Religious practices, such as prayer, were important in the lives of participants. Most of participants believed that health professionals should consider their religious needs as part of their health care. For example, Habib believed:

It would be great if they think about religious issues and improve such great services. (Habib, p. 40, L: 1176-1177)

The mandatory five daily prayers are addressed in the participants’ stories and they insist they must perform these prayers during their hospitalisation, except when they had an excuse to not do so. Marzieh described how her ritual religious practices were important for her while she was in the hospital.

No matter where I am. I should pray even in the hospital. (Marzieh, p. 9, L: 254-257)

Sarah insisted the importance of prayer in her life and the need to pray in the hospital while her health condition was not enough well to get up the bed. She related:

Salaat [prayer] is the central and principle form of Islamic worship, and we must be observed with all its rituals including wudhu [a ritual ablution] before performing prayer. But how could I keep this in mind while I was in
I found another important aspect of the Muslim patients’ requirement in Shakira story. Shakira’s story in regard to her experience of losing her baby in the hospital was a story that reflects the sounds and silences of voices other than her own. As a general rule, there are no complicated or elaborate rites performed when a Muslim is dying and the body must be handled with care and respect and burial should take place as early as possible.

When a Muslim is near death, those around her or him are called upon to give comfort, and reminders of God's mercy and forgiveness. They may recite verses from the Quran, give physical comfort, and encourage the dying one to recite words of remembrance and prayer. It is recommended, if at all possible, for a Muslim's last words to be the declaration of faith: ‘I bear witness that there is no god but Allah’. The eyes of the deceased should be closed, and the body covered temporarily with a clean sheet and the body has to be buried as soon as possible (Al-Shari, 2005; Rippin, 2006).

Death is a very painful and emotional time. Shakira recalled her experience and feeling when her baby died and she wished hospital staff could treat her baby in the Islamic way:

*I liked someone would help us to say Shahada and recite Quran when my baby died. I liked they knew how to prepare and shroud my dead baby in Islamic rites. But nobody... [pause] I felt really lonely and helpless. You think it wasn’t hard that my husband should do these?* (Shakira, p. 29-30, L: 865-871)

For Shakira’s family it was imperative to prompt her baby with the Shahadah, bearing witness that there is no true God but Allah and Mohammad is verily His servant and His messenger. She also said they couldn’t find the holy book of Muslims, the Quran, to recite when her son’s death approached:

*I asked them to have a holy book, but... [pause].* (Shakira, p. 30, L: 874)
Shakira suggested it would be great if hospitals provide a Quranic audiocassette and play it at the bedside of the dying Muslim. Shakira recounted that they asked nursing staff to reposition the baby to Mecca:

_We [Shakira and her husband] wanted our son to be faced to Mecca, so my husband asked them for it._ (Shakira, p. 30, L: 876-877)

She added my husband had a problem finding the direction of Mecca in the hospital. Shakira criticised the lack of knowledge among health professional and available services for Muslim patients in such case and said to me that:

_{Once death of our son was pronounced, I liked my family would be around in such tough period and they would prepare him for funeral rites._} (Shakira, p. 30, 886-887)

Yasamine highlighted the notion of the centrality of religion in Muslims’ lives.

_{...it was often because the hospital staffs underestimated the importance of religion and impact of these beliefs [religious beliefs] on my everyday life. So they did not account for them. They need a more formal understanding and consideration of beliefs, expectations, preferences, and behaviour of the Muslims to ensure that they providing the best and most complete care possible._} (Yasamin, p. 14, L: 399-404)

The participants in considering the practices and beliefs that set them apart, that is the things that make them different, are the aspects of their everyday life that make them Muslim. They stressed that these things were part of their everyday and they were not extraordinary. Therefore they considered the need to undertake these practices as basic needs and fundamental to being Muslim. Although there is the possibility of forgoing these observances this would only occur in extreme circumstances. Inevitably the participants were drawn to consider why their circumstance prevented them from being Muslim, from doing those things that define them as Muslims and this is the focus of the next sub-theme to emerge from the participant’s experiences.
7.3.2. Hindrances to Being Muslim

**Hindrances to Being Muslim** is the next sub-theme to be discussed. The challenge of living-Islam-in-the-non-Islamic-hospital is one that begins with an awareness of self that is typified by a feeling of being an outsider. This caused the participants to consider themself as different, with the need to undertake a range of religious observances which allowed them to be Muslim. Participants voiced that their experience was one of being hindered in undertaking these observances. I came to understand this as a constant state of trying to live Islam in an un-everyday world and this appeared to be a dominant issue referred to repeatedly throughout the interviews.

I understood the often silent discomfort of participants who having found themselves in a non-Islamic hospital, were faced with a range of barriers which hindered their ability to live Islam, to be a Muslim by undertaking what was considered to be basic and everyday activities. These hindrances were manifest in differing ways. In some cases it was the lack of facilities that proved a hindrance. In many cases it was viewed as a lack of knowledge or understanding. The following section explores this aspect of the participants’ experience.

In the previous section the participants experienced Being different. The difference related to them Being Muslim and this was centred on a range of observances, practices and interactions that are fundamental to living Islam. The major issues were around the need to pray, modesty (particularly in relation to dress and gender issues) and dietary conventions. These issues again feature with this sub-theme but the focus of this experience is in relation to barriers or hindrances in being able to undertake these observances and practices.

Yasamine recalled:

*I knew the food is not halal. So, I didn’t take any food in the hospital.*

(Yasamine, p. 12, L 333-334)
Yasamine’s story enlightened that although hospitals provide patients with a choice of meals and snacks on the wards, including vegetarian, they were often unable to take food during their hospitalisation.

Many of the participants in this study were unsatisfied with food provision. For example, Hamid recounted:

*There was nothing you can do about it [hospital food]. As a Muslim, I couldn’t take it.* (Hamid, p. 47, L: 1383-1384)

Yalda also said to me that:

*Well, I don’t know if I didn’t like to eat vegetarian food what I would eat [during her hospitalisation period].* (Yalda, p. 62, L: 1851-1852)

The experience of the participants was one of contemplation about the lack of provision of appropriate food:

*I think consideration has not been given to use the halal meat.* (Akbar, p. 21, L: 629)

To be Muslim is to behave and to be treated in a manner that emphasises modesty. Participants found themselves in many situations where this need for modesty was difficult to achieve.

Sarah said to me that:

*I’m asking why the hospital shouldn’t have appropriate dress for me and why I had to cover myself with sheets and ...* (Sarah, p. 19, L: 573-575)

The following excerpt from Yalda is a typical example: She related in her story that:

*In the hospital, I found that they not consider gender as an important issue. So it was routine male nurses were allocated for female patients. But you know for Muslims it’s just unacceptable when there is any other alternative.* (Yalda, p. 61-62, L: 1830-1832)

Akbar recalled the challenge for him of having his basic needs met and narrated:
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After operation, I needed to void but I should use bottle. I felt uncomfortable. I felt embarrassed about asking bottle from female staff and liked to wait until she [the nurse] asking me. (Akbar, p. 22, L: 639-644)

Perhaps not surprisingly was the recurring experience of difficulties around meeting obligations relating to prayer. The following excerpt from Hussein’s story is one example:

When she [the nurse] entered to the room to do observation, I was praying. She found I huddled on the floor, mumbling. At first, she thought I had fainted, fallen off the table, and perhaps struck my head. But when she tried to help me up, I became agitated and resisted her help. I couldn’t speak at the time of praying, and she had no idea what I was doing at the time. (Hussein, p. 52, L: 1547-1552)

Ali also emphasised the importance placed on prayer in his life and pointed out the lack of prayer room for Muslim patients. As he told in his story that he preferred to pray in a prayer room and added:

It isn’t like to say ‘don’t bother yourself; don’t need to pray in hospital’. I did pray in front of other patient even though it was extremely difficult. (Ali, p. 33, L: 985-990)

The sub-theme of hindrance to being a Muslim goes beyond the recognition that there are barriers to living Islam. The participants were drawn to consider why these hindrances existed.

Sarah and Habib, for example, said:

I expected they [nurses] would know the basic things about Islam at least. (Sarah, p. 16, L: 470)

Yalda believed many hospital staff lacked education about Muslims’ customs and practices. She recounted:

Most of the nurses have had no enough information about Islam and Muslims. They only know that Muslim women put on a headscarf. They know very little about the needs of Muslim people. ...Some nurses were surprised when they heard that Muslims shouldn’t eat pork and drink alcohol; or they must pray five times a day. (Yalda, p. 63-64, L: 1889-1897)
Lack of knowledge was not the only reason that participants perceived that needs were not being met. Shakira stated:

*Remembering the time, which I was asking help, makes me to feel uncomfortable. I think the reason why they didn’t hear my voice was that they were too busy. Still I believe if I was one of them... [pause], my baby was alive now. However I’m not sure whether it was intentionally* (Shakira, p. 27, L: 788-796).

Participants were careful to relate that although as Muslims they have needs that are common to other Muslims they wished to be treated as individuals and not to be stereotyped. As Akbar related:

*They [health professionals] need to see people as people. It is very important that they have to know where the patient is from and his whole history and background, to really appreciate him, but not to judge him. ...If they are interested in the whole person, then they sort of have to know that the person needs.* (Akbar, p. 25, 731-742)

Huda was typical of tens of thousands of Muslims who do not practice all of the Islamic principles. Again this emphasises that to meet the needs of Muslims the participants believed care should be taken about stereotypical assumptions. She related:

*She [the nurse] told me, “I looked after a Muslim patient before. I know you eat halal”. But I said I don’t care if the food isn’t halal.* (Huda, p. 57, L: 1681-1684)

When Huda explained that she does not pray and eat non-halal food, I remembered the interview which I did with Hussein. Hussein claimed that Muslims believe that:

*There are three types of believers among those who follow Islam. Nominal Muslims are born into a Muslim family or an Islamic state but do not practice their religion. They have not committed themselves to observing the five pillar of Islam. Traditional Muslims usually have some rudimentary knowledge of fundamental Muslim beliefs. True Muslims understand their professed faith and strive to live their lives in accordance with its teaching* (Hussein, p. 55, L: 1624-1638).

Hussein added that:
It is all too easy to say; Muslim patients do not eat pork; Muslim patients do not drink Alcohol; they eat Halal; they pray five times a day. But we must remember that these thoughts are gross generalisations. Although Muslims are supposed to be, there are individuals within Muslims who often have characteristics quite opposite to the stereotype (Hussein, p. 55, L: 1644-1649).

Fatima indicated that providing individualised care is the nurses’ responsibility. She thought it was important for the nurses to ask about her culture and religion, to appreciate the fullness of her experience and background:

*For [some] nurses, all of us were patient. No matter where we were from... [but] Patients may be in different. ...It is the nurses’ tasks to find out how treat patients and manage differences.* (Fatima, p. 41-42, L: 1211-1236)

Fatima with frequent admissions criticised health professionals and said:

*...it not issue why most of them don’t know much about Muslims, I like to ask whether they like to know? If yes, so why don’t talk to us and try to understand who we are, not what we are.* (Fatima, p. 41, L: 1225-1226)

Such experience can readily cascade into other aspects of inequity such as disparities, unfairness, and unequal treatment. As Shakira was feeling her baby had been mistreated by the hospital and pointed out in her story:

*If I wasn’t a Muslim, my baby was treated in the way I liked… [pause] or better to say my baby was alive.* (Shakira, p. 30, L: 876)

Hamid believed some health professionals recognise the Muslims’ specific needs, but the response to these needs was one of compromise.

*It was like I don’t have a history or anything. [Some] nurses knew what Muslims need but they didn’t take care. They were assuming illness. They were just assuming I was a sick patient and this is what I needed to be in the hospital. But you know I was within that illness.* (Hamid, p. 47, L: 1384-1388)

The experience of the participants was one where they were hindered in meeting some of the basic obligations which are central to living Islam. In most cases the participants did not voice that this was intentional. For the most part they viewed this as a lack of
knowledge and understanding by nurses and other hospital staff. There was also recognition that there was a danger of being stereotyped and that this may lead to care that lacked sensitivity to their individuals needs. In this way the hindrance to Being Muslim is not simply a lack of understanding of a cultural group but also of the individual. Take, for example, Muslim women. Muslim women have the reputation outside their religion of being modest. Health professionals might generate an oversimplified impression of the characteristics of Muslims women as a whole and easily conjure up a portrait of what a Muslim woman patient is like. This is a stereotype and masks individual differences within Muslim population.

The next sub-theme draws immediately from the experience of hindrances to Being Muslim. The recognition that needs are not being met and that this is a result of specific barriers brings the participants to explore ways of dealing with this predicament.

7.3.3. Adapting-to-the-un-everyday-world

Living-Islam-in-the-un-everyday-world necessitates changes to accommodate the existing conditions. Adapting-to-the-un-everyday-world for the purpose of this study means how participants sought to accommodate Being the same and different. From the participants’ stories, I found that they attempted to fit the experience of Being-in-the-un-everyday-world into their daily life. Therefore, the sub-theme encompasses the participants’ attempts to gain some measure of control and move back to their normal everyday life, which was a significant challenge for many of the participants.

Adapting-to-the-un-everyday-world required strategies to minimise the challenge of living Islam in the hospital. This entailed assessment of the problem, recognising limitations, and identification of potential solutions. Within this sub-theme, health professionals, participants’ family and friends all played a significant role.

For some participants, the result was a silent challenge and their experience was typified by withdrawal. Yalda said in her story that:
Once I was in the hospital, my meal was brought and left on the table. I couldn’t get up to take it. I was shy to ask someone to help me and nobody asked me whether or not I like to eat. Some hours after, they took the food cold and in the same place. (Yalda, p. 63, L: 1872-1875)

It was not uncommon for participants to deal with their circumstance by refraining from raising the issue at hand with the staff. Akbar recalled his silent challenge:

After operation, I needed to void but I should use bottle. I felt uncomfortable. ...I felt embarrassed about asking bottle from female staff and liked to wait until she [the nurse] asking me. (Akbar, p. 22, L: 639-644)

Negotiating the challenges and reaching satisfaction was often difficult. Some participants expressed difficulty in dealing with the confronting nature of their predicament. Sarah said:

I’m asking why the hospital shouldn’t have appropriate dress for me and why I had to cover myself with sheets and towels that she [the operating room nurse] looking at me in such way. I didn’t like the looks I got from her, the look that says, you are barbarous person, how glad I am that I didn’t have such problem much. (Sarah, p. 19, L: 573-575)

This experience of withdrawing was not always prolonged. Sarah, for example, commented:

It was really uncomfortable. I prefer to be in a private room. But it was difficult to request it and I didn’t feel I had any power to ask that. I don’t know whether it was right or not anyway. ...I wanted to... [pause] I just had to ignore it. But after few days, I felt safe to ask. (Sarah, p. 17, L: 491-502)

Although some participants adapted to their circumstance by withdrawing many took up the challenge by actively pursuing solutions to their predicament. They described alternatives ways to manage their daily life based on Islamic lifestyle or to live Islam in the non-Islamic hospital. These strategies were used by participants in this study to maintain a sense of normalcy. Marzieh, for instance, recounted that:

I checked the menu and understood there was nothing to show hospital’s food is halal. I asked the person who was serving food whether the food is halal? Interestingly, I understood she knew nothing about halal food. ...I asked my family to provide meal that I would eat it. They cooked and brought food for me everyday. (Marzieh, p. 8, L: 215-226)
The participants also wanted to stress that Islam provides a group of concepts and values for Muslims that function as powerful adapting strategies in the face of difficult situations. Take, for example, gender issues. Islam allows Muslim women to be cared by male health professionals where there is no possibility to allocate a same gender health professional. As Marzieh voiced:

*I wanted to refuse but my condition was an urgent one.* (Marzieh, p. 6, L: 175)

Such adapting strategies were explicated in Shakira’s story. Shakira understood her urgent situation and accepted a gynaecological exam by male doctor when she was in the emergency department but she refused this exam when she was in the ward and her condition was stable. She said that:

*Well, when I went to hospital, there was no female doctor and my gynaecological exam was done by a male doctor. ...A gynaecological exam needed to be done the next day. I asked for a female doctor.* (Marzieh, p. 6-8, L: 173-182)

Yasamine who initially reacted to the problem of not having Halal food available by withdrawing but eventually sought other solutions. She asked friends to provide halal food for her as she pointed out:

*I never ate hospital food in the period that I was in the hospital. My friends provided food for me.* (Yasamine, p. 15, L: 430-431)

Akbar had another alternative for providing a food according the Islamic law. He said to me that:

*You know Muslims can eat vegetables, seafood and diary products. ....It was not too difficult to eat dairy products and vegetable for few days. So I just ate such foods.* (Akbar, p. 24, L: 708-717)

Shakira also related in her story:

*He [the boy friend of the patient next to her] was there most time, I asked to be in a private room because my dress wasn’t appropriate.* (Shakira, p. 28, L: 830-832)
Participants voiced they preferred to be admitted to a unisex ward or in a private room. The story of Husein is an example of participants’ stories:

...I continued to wear a casual cloth. I was in shared room with few other patients. The patient next to me had visitor. My cloth caused some discomfort when his partner was there. I had to be careful how I sat and also when standing up and sitting again. I kept moving curtain just enough to allow some modesty. (Hussein, p. 54, L: 1611-1615)

Hussein believed that the format of the prayer can be modified according to the person’s predicament. Ali also recounted that:

I was praying in the bed when I was not able to get off the bed. (Ali, p. 33-34, L: 990-991)

The following excerpt from Hamid’s story is another example of Muslims requirements for having a prayer room in the hospital:

I was happier if I would pray in prayer room but I did pray in the room. (Hamid, p. 48, 1435)

Ali and Hussein related how they found a reasonable solution in order to provide privacy for praying in the hospital. Ali told that:

I was pulling the curtain when I wanted to pray. (Ali, p. 32, L: 933)

For Hussein working with staff to achieve a solution was a logical strategy:

Getting up in the early morning for prayer while there is someone in one side who doesn’t believe God and a person who believes another religion in the other side was challenging. I was always worried to disrupt their sleep. ...Imagine how hard would be when you are going to pray in the early morning when everyone was sleep. I felt very shy when I saw he [the patient] was gazing at me to see what I was doing. I thought he was telling himself how crazy I am. If there was a prayer room why I had to... I had this idea in my head, with a bit of help from nurses; I could pray in TV room where there was no one there at that time. (Hussein, p. 53-54, L: 1579-1596)
Clearly a number of the participants were keen to discuss Islamic practices that incorporate Muslims’ everyday life. They felt that greater understanding of their faith by staff was clearly an important way of achieving their goal of living Islam.

Participants felt cared for when health professionals showed that they were concerned for their patients’ welfare and appreciated health professionals who were interested in their religious practices. As an Example, Hussein said:

*I would pray that most of them [nurses] were interested in that certain area, and be interested in their patients, and interested in finding a comprehensive care for patients and they were interested or educated in whatever it is.* (Hussein, p. 54, 1597-1600)

Akbar said to me that:

*Understanding of different cultures is important. And so many [health professionals] that I have encountered in the hospital were capable of handling the differences between Islamic culture and their own culture and respected me. It was nice that I would tell them I’m Muslim* (Akbar, p. 25, L: 723-727).

However Shakira argued that:

*...nurses did not seem to know about our religion. Nobody asked much about any specific religious needs. They knew I was a Muslim as they asked me that when I first came on the ward. That was the end of that. I think they just ask because they have to fill in the forms.* (Shakira, p. 28, 805-809)

She added:

*They [Health professionals] are not interested in Muslim patient, because they don’t have the multicultural knowledge, they don’t have the temperament and they take the attitude, “you are Muslim so what?” And that is a bad attitude. Being a Muslim patient is one thing but “so what” is another.* (Shakira, p. 30, L: 881-885)

The concept of respectful engagement is described as experiences of interpersonal interactions in health care settings that were characterised by the perception of support, caring, empathy, acceptance, and respect towards the participants by health professionals. The notion of respectful engagement was not only a recognition of
aspects of the Muslim faith. In some cases it was conversely experienced as being treated the same as everyone else. Sarah was grateful for the care provided by a male nurse. She related in her narrative how one health professional made her to feel respected.

*I knew he [the nurse] didn’t care if his patient is Asian or Middle Eastern or whatever, he acted like I’m an Australian. Offered me coffee and other stuff I needed.* (Sarah, p. 17, L: 482-484)

Respectful engagement was seen as significant to satisfaction with the care, as expressed in words of one of the participants.

*I felt better when she [the nurse] was asking what I like. That's a start. But full satisfaction is when there is no difference in health care. I’m sure everyone feels good when they are satisfied.* (Hamid, p. 49, L: 1457-1459)

Participants’ narratives indicated the importance of the nurse helping them, meeting or attempting to meet their needs. As an example the following extract of Huda’s story demonstrated how she felt safe to be looked after by a male nurse. She accounted that:

*I don’t know that I remember exactly what he did that helped me. But I was able to accept the fact, and have enough trust in him [the male nurse] that whatever he was doing was going to help me. He helped me in such horrible situation to get better, so, why not let him to do what he wanted to do?* (Fariba, p. 1-2, L: 29-33)

Trusting nurses and other health professionals was essential for participants to feel safe. Although participants were vigilant and expressed concern about their care, almost all of the participants felt safe being cared by the hospital staff. As Huda said:

*Well I think for me, the best thing was that I did feel safe.* (Huda, p. 58, L: 1726)

In adapting-to-the-un-everyday-world the participants were experiencing, a variety of strategies used to meet the challenge presented. There is no intention here of judging the strategies that were used but merely illuminating this aspect of the experience of living Islam in an un-everyday world. On the one hand participants experienced withdrawal choosing the path of a silent challenge. Others were able to work with staff to fulfil their obligations although often in less than ideal circumstances. Others recognised the
importance of better knowledge and understanding by staff and were pleased when this was achieved.

As Yasamine related:

*I needed to be sure that she knew I am a Muslim, not a stupid person. I did feel good when she understood why I wrapped myself round the sheet.*
(Yasamine, p. 12, L: 358-359)

### 7.4. Summary

This chapter presented the interpretation of the participants’ stories, and described themes and sub-themes which were derived from the thematic analysis. Two themes emerged from data analysis of the phenomenon of the challenge of living Islam in non-Islamic hospital. Within the first theme, Being-thrown-into-an-un-everyday-world, sits the sub-themes of the awareness of self and Being an outsider. The next theme, living-Islam-in-the-un-everyday-world, sits the sub-themes of Being the same and different, hindrance to Being Muslim, and adapting-to-the-un-everyday-world. Throughout these themes, the meaning participants attributed to their experience of Being a Muslim patient was revealed and made explicit to the reader. Presenting data in this way provided the means to derive a meaningful ontological interpretation of the essence of Being a Muslim patient in non-Islamic hospital. In the next chapter, Chapter Eight, the ramifications of these themes will be discussed and suggestions will be created from the data with the intention of informing health professionals for caring Muslim patients in Australian hospitals.
CHAPTER EIGHT

DISCUSSION OF FINDINGS, IMPLICATIONS, AND CONCLUSION

8.0. Introduction

The hermeneutic phenomenological approach to inquiry seeks a deeper understanding of phenomena through analysing accounts of human experience in a particular context. It asks “what is the essence of the phenomenon” through asking those who have experienced it to richly describe their experience (van Manen, 1990, p. 9). The intention of this study was to find the meaning of the experience of Being a Muslim patient in a non-Islamic hospital where adherents to Muslim faith were in a minority. Thus, the study asked people from an Islamic background to describe their experience in an Australia hospital. Using a phenomenological-ontological perspective, these descriptions were analysed to elicit the meaning of the phenomenon.

This chapter discusses the overall findings of this research and highlights the limitations of the study. Then the chapter compares and contrasts the participants’ perspectives with the relevant literature. A number of recommendations for clinical practice and education are outlined, and areas for further research are suggested. The chapter makes
explicit the unique findings and contribution of this study. Finally, a conclusion to the study is provided.

8.1. Overview of Findings

The phenomenon of Being a Muslim patient in non-Islamic hospital was described by the study participants from the context of their own unique experience. In order to tell me about their individual experience of this phenomenon, participants needed to talk about the reasons for and background to their hospitalisation and to describe their experience from admission to discharge. The findings from this study, presented in Chapter Seven, provide valuable insights for all those involved in the care of Muslim patients that may have implications for nursing practice and hopefully enhance patient care.

Two themes emerged from a thematic analysis of the participants’ lived experience of hospitalisation in this study. The themes were titled: **Being-thrown-into-an-un-everyday-world** and **living–Islam-in-the-un-everyday-world**. These themes reflected a holistic picture of the phenomenon of the challenge living Islam in hospital, and included both physical and psycho-social aspects of the phenomenon. The amalgam of the physical and psycho-social aspects of the patients’ hospitalisation experience is an important part of nursing practice but one that is not often achieved (Yen, Chen, and Chou, 2002b). While many nurses are competent at maintaining the physical body of patients, there is too often a lack of understanding or de-emphasis of the psycho-social effects of hospitalisation (Shih et al., 2005). The area of multicultural nursing provides nurses with a challenge to address both the physical and psycho-social aspects of the Muslim patients.

The interpretation of the participants’ stories highlights Muslim patients’ struggle to maintain their Islamic lifestyle during hospitalisation in a non-Islamic hospital. Being a Muslim patient in non-Islamic hospital was a challenging experience. This has
previously been neglected by researchers, who have focused on more general aspects of care (Lundqvist, Nilstun, and Dykes, 2003; Ohm, 2003; Tsianakas and Liamputtong, 2002; Vydelingum, 2000). There has been little exploration of the psycho-social impact of hospitalisation on Muslim patients.

This study discovered that participants experienced the non-Islamic hospital as Being-thrown-into-an-un-everyday-world. This was reported by patients as a disconnection from their usual way of Being-in-the-world. The participants reported that when admitted into an Australian hospital they felt removed from their everyday world and thrown into an unfamiliar world. For instance, Huda said that she found the hospital to be a different world. And Sarah described it as being in the middle of an unknown world. The findings show that as participants entered into this un-everyday world of the hospital, they were confronted with an opportunity to critically think about themselves and others in this unfamiliar world. The story of Marzieh is a typical example. Marzieh explained how her normal life changed after admission to the hospital and how she was thoughtful about the place she was in. The findings show that Muslim patients develop an awareness of self as Being an outsider, uneasy, lonely, and isolated. For example, Akbar said in his story that he felt totally alone. A profound loneliness is also recounted in Yasamine’s story.

This study found many consequences related to Being a Muslim patient in a non-Islamic hospital. These consequences were evident in the second theme titled ‘living-Islam-in-the-un-everyday-world’. The theme exposed what it meant for participants to be hospitalised while adhering to the Islamic world. For the participants in this study, maintaining their Islamic lifestyle was experienced as a challenge with hindrances and barriers to be overcome. As an example, Ali in his story referred to food and prayer and said that he wished to be discharged because everything was going to be hard. Adhering to the Islamic lifestyle was a major concern of the participants. This showed in the participants’ stories in this study. Fariba said that religion plays a major role in her life. And Hussein told how he practically lives in a religious world. For Shakira, religion was not something set apart from her life.
Living-Islam-in-the-un-everyday-world also refers to the different requirements of those who adhere to Islam, which were often ignored in their care provision (for example, the provision of halal food). Hussein, Ali, Akbar, Huda, and Fariba described how the hospital dietary services were not adapted for their specific needs and the lack of provision of halal food. Other conventions and practices that were a focus of concern included prayer, gender segregation, dress codes and managing the care of the dead from an Islamic perspective.

There was a recognition that although the need to become well was important, the need to be Muslim was equally important and this need was often not being met. These particular aspects featured in all the participants’ stories and impacted substantially on the meaning and interpretation that they attributed to the experience. The participants experienced a lack of knowledge and understanding by health professionals in relation to their dietary requirement, prayer, gender segregation, and dress code. For example, Yalda believed many health professionals do not consider gender issues in Muslim patients’ care plans because of a lack of knowledge. Furthermore one participant commented about the lack of knowledge about dealing with the dead from an Islamic perspective. The challenge, therefore, was to meet the specific needs and this was evident in the experience of the participants in adapting-to-the-un-everyday-world. This was seen as particularly positive when nurses and other health professionals actively worked to assist Muslims in meeting their specific needs.

8.2. Limitation of the Study

The recognition of limitations will assist the reader to understand the scope of this study and to evaluate the implications of the findings as presented. The limitations largely stem from the methodology used in this study. The methodology used, as with other qualitative approaches, is considered to have a number of inherent limitations. It can be argued however that some of these limitations are perceived and are not legitimate
criticisms of hermeneutic phenomenology. In particular, the issue of generalisability should be considered.

While the findings from this study add to the body of knowledge about the phenomena of Being a Muslim patient in a non-Islamic hospital, these findings are not transferable to a wider population. This of course is not the intention of the study. The findings of this study like other qualitative research studies “…generalise to theory rather than to population” (Bryman, 2001, pp. 282-283). The aim of the study is not to provide a basis to predict behaviour or to establish cause and effect. The aim is to illuminate and provide an interpretation that assist in understanding.

It may also be conceived that the low participant numbers (thirteen participants in all) included in this study could be seen as a limitation. Considering the methodology and the density of the data gathered, the measure of what is sufficient does not relate to the number of participants but to the sense of completeness brought by the findings. It became clear during the study that fewer participants would be too small a number, and more, too large. This judgment is based on the material uncovered in the research process.

The need to use purposeful sampling means that the study was biased from the start. This is, of course, one of the major criticisms of this type of research. Again the intention is to seek out the phenomenon, to find deep meaning and understanding. The process is necessarily directive and although it introduces bias the validity of the findings should be measured on how these biases are managed through the interpretive process.

Another limitation of the study is that it is retrospective in nature and relied on participants’ recollection of their lived experience after discharge from hospital. The stories were told after a period from two weeks to four years following the experience. Previous studies have shown that the ability to recall events differs markedly between studies and over time (Parker, 1997; Russell, 1999). Therefore, the accuracy of recall may have been distorted as a result of the passing of time. This is difficult to determine.
It should be stated, however, that it was apparent that the experience of participants were extremely emotional and that were vividly recalled.

In dealing with a specific cultural group a number of issues arose that presented unique limitations for the study. Language in particular is an important factor when data collection relies on interview. English was not a first language for many of the participants in this study. Although Muslims in the region of the study setting speak many languages, the researcher was only fluent in English and Farsi. This study, therefore, was restricted to participants who are able to converse freely in English and/or Farsi excluding some individuals who would have liked to discuss their experience. The participants who were interviewed had varying levels of comfort with the language and most appeared to struggle with the language. Over and over again, the lack of ability to communicate in English posed a strong block to participants’ ability to identify and address issues.

It should also be noted that participants are almost entirely Middle Eastern and were born and grew up in an Islamic country. There are no Muslims who were born in Australia. However, there was no intention on my part to produce a representative example of the meanings that Muslims from other parts of the world or a person who was born in a non-Islamic country attaches to hospitalisation. It is possible that the experience of participants could be quiet different if Australian-borne Muslims were involved as participants. Clearly, further research is needed to explore the different issues for Muslim patients, and explore how the experience of Being a Muslim patient in non-Islamic hospital is affected by ethnic background and the country of origin.

Other cultural issues presented some additional challenges. In the current socio-political climate the sensitive nature of the topic may have led to some participants feeling hesitant to share the important aspects of the experience. Some compromises were made on ethical grounds. It was evident that the small size of the Muslim population in South Australia would present challenges for participants particularly in relation to concerns about confidentiality. However, Being a Muslim as a researcher might have helped these participants to feel more comfortable to describe their experience as fully as they could, thus minimizing this limitation.
A particular important issue related to the presence of others during interviews. Most of the participants’ interviews were conducted in their homes when their family members were present. Participants possibly could have limited what they were willing to share if they thought the family member might hear. I was aware that the presence of family members might have influenced what the participants were willing to share. But culturally and morally, it was not possible to ask family member to leave interview. Research in which the researcher and the participants come from different contexts and communities always presents challenges (Brodsky and Faryal, 2006; Clingerman, 2007). However being a Muslim as a researcher might have helped these participants to feel more comfortable to describe their experience as fully as they could, thus minimising these limitation.

The goal of this research is to represent adequately the realities of Being a Muslim patient in a non-Islamic hospital. As the researcher is a Muslim, this may be limiting in that this brings a specific perspective and world view that necessarily impacts on the interpretation. The researcher to some degree brings to the interpretation the perspectives of an insider. This may create some difficulties for the reader as an outsider from another cultural tradition to engage with the interpretation as the researcher intended.

The findings from the study may be used to help guide the care planning of Muslim patients. One of the dangers in writing a guide to cultural care is that the guide reports on normative behaviours. In the case of this guide, the normative behaviours refer to cultural norms for the Muslim World. Even in the Muslim World, there are over hundred different countries, numerous sub-cultures, and religious and ethnic minorities. In addition, one of the greatest aspects of Islam is cultural change through acculturation and assimilation. Therefore, a great danger lies in producing a guide for Muslim patients and findings this study must be applied with caution.

The time and resource constraints of completing a PhD necessarily limited my focus. Due to resource limitations and time restraints only Muslim people who resided within
South Australia were targeted for recruitment, as this was where I was based and would practically facilitate the conduct of interviews.

Finally, in terms of the study as whole, it has predominantly taken shaped in and through my interpretive work. My religious and cultural background then has necessarily limited this work and it is inevitable that my own perceptions, values, and religious beliefs have had some impact on the findings. However, the nature of hermeneutic study recognises unconditional imperfection of all effort to understand (Gadamer, 2003). I acknowledge that I am only ever contributing an element in the stream of understanding. This interpretation therefore is to be judged on believability and not on a presumed totality of the Muslim patients’ experiences in an Australian hospital.

In summary, although there are limitations to the findings, the knowledge derived from this study substantially adds to our understanding and what is currently known about what it meant to be a Muslim patient in a non-Islamic hospital and may inform culturally sensitive care practice. The next section explores the overall finding of this study in relation to the relevant literature. I argue that such an exploration may allow the voice of Muslim patients to be better heard and contribute to culturally sensitive health care experiences.

8.3. Discussion of Study Findings

Hermeneutic phenomenology “attempts to gain insightful descriptions of the way people experience the world pre-reflectively” (van Manen, 1990, p.9). It does not offer us the possibility of effective theory with which we can now explain the world, but rather “it offers us the possibility of plausible insights that bring us in more direct contact with the world” (van Manen, 1990, p.9). Hermeneutic phenomenology has always had a special role in furthering knowledge. For Muslim patients, hermeneutic phenomenology had an important role to play in both reaching an understanding of the
reality of participants’ daily life in a non-Islamic hospital and in creating a space for participants’ voices to be heard.

For the participants, the experience of Being a Muslim patient was not only personal, but also was transactional, communicative, and profoundly social. This is in keeping with Warnock (1970) who believes a human being cannot be taken into account except as being an existent in the middle of a world amongst other things. The ontological question of ‘What does it mean to be a Muslim patient in a non-Islamic hospital?’ is also the key to Heidegger’s (Annells, 1996) phenomenological view of the person. According to Heidegger (1996), Being –always capitalised– is that primordial state that enables everything else to come into existence.

Heidegger’s term for human existence is ‘Dasein’ and is the key to the meaning of Being in general. Heidegger (1996) believes our existence is defined by the fact that we are Being-in-the-world. “Dasein always understands itself in terms of its existence-in-terms of a possibility itself: to be itself or not itself” (Heidegger, 1996, p. 33). By using the expression ‘Dasein’ Heidegger (1996) called attention to the fact that as essential characteristics of human beings is that humans are individuals who are only tangentially related to others and the world. Heidegger is seeking to avoid the subject-object model which interprets human being in a manner which disrupts the relational manner in which they find ourselves within the world; as part of the world of one another, not apart from it. He uses the term ‘Being-in-the-world’ which is ‘to be there’ and ‘there’ is the world (Heidegger, 1996).

Accordingly, Being a Muslim patient literally means Being ‘there’ and ‘there’ means a non-Islamic hospital. I understood that Being a Muslim patient in the non-Islamic hospital is not extrinsic to participants’ existence. In other words, the participants in this study are not isolated individuals who then enter into relationship or subsequently take up dealing with the world. I understood the participants as Being present in the hospital (even to themselves only as Being-in-the-world). Therefore, according to Heidegger (1996), their existence has to be considered within the framework and against the background of the life-world into which they were inserted. As such the Muslim patients do not exist in the hospital without the other people, patients and health
professionals. The study showed that the phenomenon of what it is like to be a Muslim patient in an Australian hospital was a challenging experience for the participants.

The study showed that participants felt thrown into a completely different world that was out of touch with the everyday world (evidenced in the stories of Sarah, Huda, Hamid and Hussein) when participants entered the hospital. For example, Hamid described his feeling and said he felt separate from the world. This theme indicated that participants felt profoundly distanced from the pre-hospitalisation and post-hospitalisation worlds. This was borne out by Fariba’s story and Marzieh’s story. According to Marzieh, before her admission to the hospital she had a normal life as others do in society. But her normal life was disrupted after the admission and she felt her life was not normal any more. It is interesting to note that the concept of ‘thrownness’ is a key concept in Heidegger’s phenomenology. It refers to basic conditions of the world that humans are thrown into. Thrownness is Heidegger’s way of revealing and expressing the existential experience of ‘Dasein’, as thrown humans submit to the world, and exists tactically with others (Heidegger, 1996).

The concept of ‘thrownness’ is relevant to this theme as the participants have been thrown from their familiar into an unfamiliar environment of a non-Islamic hospital. A review of existing literature showed that Being-thrown-into-an-un-everyday-world following admission into hospital as a patient from a different cultural background has not been a previous area of research. This study showed that the experience of Being-thrown-into-an-un-everyday-world was a product of the mind and involved an awareness of self and the feeling of Being an outsider.

Being-thrown-into-an-un-everyday-world began with a self-awareness that then developed into a discomforting perception of Being different from other patients. The self-awareness of participants was a unique type of consciousness in that it was not present before their hospitalisation, and was not sought after. As an example, Sarah related that her admission to the hospital led her to a new awareness about herself. In the normal daily life context such as at work, restaurants, on public transport, participants were seldom aware of their sense of Being-in-the-world. This is evident when Huda said, she had been in Australia since 1996. “….I did not feel like this when I
was on the bus but I did when I was in hospital”. Sarah recalled that her hospitalisation led her into a new awareness of her likeness. Gadamer (1989) distinguishes three modes of engagement that people have with their surroundings. He uses the example of a hammer. When using a hammer, we have no need for focal awareness of ourselves and our tool. The skills and practices we bring to our activity are so familiar to us, that we are simply unaware of their experience. This is the ready-to-hand mode of activity. However when some problem is encountered such as the hammer may prove too heavy for the job, its weightiness become salient. This breakdown of action represents the un-ready-to-hand mode. The present-at-hand mode is entered only when people detach themselves from an ongoing practical involvement in a project at hand. People have to step back and reflect. The hammer becomes an independent entity, removed from all tasks pursued. In ready-to-hand mode, participants’ life was familiar and normal because their behaviours and situations fit other people and they were able to go about their usual lifestyle. But admission to the hospital moved them to the unready-to-hand mode. Hospitalisation brought the awareness of being in an un-everyday world and participants felt their life did not continue on as before. The use of the term ‘un-everyday’ world while somewhat clumsy is quite deliberate in that the experience of the participants was fundamentally one of contrast from their everyday world which moved them from one form of engagement to another, the un-everyday (unready-to-hand) mode. From awareness comes understanding and the participants were then moved to the third form of engagement, present-at-hand, where the participants reflected on the meaning of Being a Muslim patient in a non-Islamic hospital. This is apparent in Yalda’s story. The need for different dietary requirements developed a new awareness of being in an un-everyday world and participants felt their life did not continue on as before.

For participants in this study, the awareness which happened following admission in the hospital was an objective self-awareness instead of a subjective self-awareness. According to Duval and Lalwani (1999), self-awareness occurs when conditions are created in the environment which allows a person to remind oneself of her/his status as a subject or an object in the world. He believes that awareness can be dually focused either outward toward the environment or inward toward oneself. Objective self-awareness is explained as a state of consciousness in which awareness is directed
inward toward the self instead of outside toward the environment (Duval and Wicklund, 1972). Thus the participants’ awareness was an objective self-awareness and was proposed when other human beings become present in the environment and the person receives and perceives feedback from the environment regarding his or her behaviors, attitudes, and practices.

Huda and Sarah experienced their self as objectively visible following admission to the hospital and they began consciously to think about their religion, their lifestyle, and their differences from people who were around them and distinguished themselves from other patients. Duval and Wicklund (1972) emphasize that attention cannot be simultaneously focused outward and inward and certain stimuli in the environment can cause this inward attention. They also assert that when a person is objectively self-aware, then he or she has become acutely aware of those personal characteristics that most distinguish him or her from others.

Different dietary requirements entered participants into a situation where they were the only one with such a characteristic. They became objectively self-aware and focused attention on that characteristic and perceived themselves as they think others perceive them. This state of objective self-awareness is generated when participants felt that they might be evaluated along such salient dimensions. This is evident in the stories of Ali and Yasamine. According to Duval and Lalwani (1999/2000), objectively self-aware persons are more likely to attribute the source of an event to themselves. The focus of attention of the participants in this study was drawn to the reality of the Islamic lifestyle, for instance dietary requirements, and exhibited salient characteristics that distinguish them from the majority.

The occurrence of objective self-awareness of the participants in this study can be understood in three ways. First, their awareness was directed awareness and the participants’ attention was focused exclusively on the self. For instance, Huda said she was thoughtful that she differed considerably from those people who been around her. Participants were the ‘object’ of their own attention, and they were seeing themselves as they thought others were seeing them. Second, induced objective self-awareness was theorised to automatically elicit comparisons between the self and perceived standards
for social correctness in terms of specific behaviors and practices. Such comparison, for example, was demonstrated in the stories of Hussein and Habib. Hussein said he doubted whether he could pray on the floor. Habib experienced uncertainty that his values and beliefs may conflict with health professionals’ beliefs and values. Finally, participants tried to reduce the negative effects of the detected discrepancies between Islamic lifestyle and the lifestyle they experienced in hospital through adapting-to-the-un-everyday-world as they feel objectively self-aware (evidenced in the sub-theme ‘adapting-to-the-un-everyday-world’).

Consequently, the study showed that the Muslim person’s experience of hospitalisation in an Australian hospital increased the participants’ level of self-awareness to an objective awareness and they saw themselves from an external viewpoint. Most of the participants in this study experienced the feeling of Being an outsider, which is evidenced in the stories of Ali, Sarah, and Akbar. For example, Akbar felt uncomfortable and alone when he wanted to pray and added he liked to hide himself. This is an important point for health professional caring for Muslim patients. For example, health care professionals need to consider that this type of awareness may be followed by personalised loneliness. This was evidenced in Sarah’s and Shakira’s stories. Sarah said she liked to be quiet because she was the only Muslim patient in the hospital. This awareness may also be experienced as isolating. This is evidenced in Yasamine’s story. She experienced that she was separated from everyone else. Yasamine found it more as a challenge of loneliness and she felt extremely lonely when she was asking different needs. And finally, this awareness may result in feelings of not belonging and of being an outsider. According to Hamid, his differences with other patients made him feel he did not belong.

Being an outsider as described by the participants is not necessarily restricted to the experience of Muslim patients. It is certainly possible to be a Muslim patient and not experience such feelings during hospitalisation and conversely this experience can be found in the experiences of other minority people (George, 1996; Shearer, 1989). However the phenomenon of ‘Being an outsider’ was a profoundly psychological aspect of hospitalisation in a non-Islamic hospital for the Muslim person. The participants’ stories contained feelings of loneliness and isolation and this experience was a
consequence of Being an outsider which was achieved by participants’ interpretation and understanding of Being different. An example of such understanding was apparent in Ali’s story. Ali believed everything in the hospital was for them. Ali distinguished himself from other patients by using the word of ‘them’ in order to describe how he felt as an outsider when the hospital services did not meet his needs.

Being an outsider fits in with prior findings that psychological aspects of care may be neglected in health care. This resonates with Yen’s findings that care should not just focus on the physical condition, promptness and effectiveness of nursing services. Therefore, according to Yen, Chen, and Chou (2002b), meeting the Muslim person’s psychological needs is important in developing culturally sensitive care. Failure to do so may result in suboptimal care for this group of patients.

The study findings demonstrated that Being an outsider in the hospital, can be experienced as a major stressor. This issue confirms the finding of number of previous studies that have descriptions of emotional experiences such as loneliness and isolation in patients from different cultural backgrounds (Clark, Drain, and Malone, 2003; Gomes and Fraga, 1997; Liu, Mok, and Wong, 2005). Such findings highlight that Muslim patients, have a substantial need to receive additional emotional support during the period of their hospitalisation.

Another finding from this study showed the participants attempts to adhere to their Islamic values and to live true to these values. As Marzieh said that it was important for her to be a Muslim woman. This relates to the sub-theme of adapting-to-the-un-everyday-world. Hospitalisation was a challenging experience (evidenced in the participants’ stories) because participants had a range of needs considered fundamental were not being adequately met. For example, they had different customs, beliefs, ate different food, and dressed differently. This finding was similar to other reported minority groups experiences (Chang, Chenoweth, and Hancock, 2003; Gaskin and Hoffman, 2000; Koenig et al., 2003). Participants’ stories and the literature review identified Australian Muslims are one of the most diverse religious groups (Allotey, Manderson, and Reidpath, 2002; Banting, 2002; Chapple et al., 2004; Galligan and Roberts, 2003) and there has been few studies of the significance of the influence of
Islamic lifestyle on the health care provision and the recognition of Muslim needs during hospitalisation (Brooke and Omeri, 1999; Tsianakas and Liamputtong, 2002).

In interpreting the stories, it became apparent that Islam is a living idea and an idea lived by Muslims. Therefore to provide care to Muslim patients it is important to acknowledge Muslims’ practices and lifestyle. In other words the participants had much to say about the Islamic lifestyle and its importance in the Muslim person’s life. The participant stories reflected that Islam is a way of life. “Al-Islam Din wa Dunya” (El-Guindi, 1995). This is also evident in Islamic literature that refers to Islam as both religion and a worldly life. The study supports the notion of Islam as providing a complete and comprehensive guidance for all aspects of everyday life. According to Islam, while Muslims may exhibit different traditions and customs, they share a single culture. What this means is that all Muslims look to the Quran and the lifestyle and traditions of Prophet Mohammad for guidance in their daily affairs. In this respect, Muslims try to implement Quranic and prophetic guidance, and therefore share a common Islamic culture, principles and values (El-Guindi, 1995).

Islamic values that are incorporated by the Muslim person into daily life are also incorporated into the provision of health care for Muslims. Although there is little exploration of the Muslims persons’ experiences of being cared for in non-Islamic hospitals, a number of aspects of Islamic lifestyle related to nursing care have been highlighted in the literature. For example, the provision of halal food (Malik, 2001), privacy, observing the hijab and segregation of genders on wards (Tsianakas and Liamputtong, 2002), prayer facility (Carter and Rashidi, 2003; Corbie-Smith, 2004; Lawrence and Rozmus, 2001; Rassool, 2004; Robertson, 1993) and visiting (Nahas and Amasheh, 1999). These aspects which are associated with Islamic lifestyle and reported in the previous research were recounted in the participants’ stories.

For most Muslims, the beliefs related to food originate from religious perspectives, “Now, eat of the lawful and good things that God has provided you; and give thanks for God's blessings, if Him only you serve” (The Quran, 16:114). In this study the participants’ need to live by this belief was not acknowledged. Food laws in Islam are important and are taken from the Quran and from the recorded saying and actions of
Prophet Mohammad (Sheikh and Gatrad, 2000). In Islam, food itself has biological and spiritual meanings. Biologically food provides the nutrients essential for life. “God created the heavens and the earth, and sent down from the heaven water. He brought forth fruits for your provision” (The Quran, 14:32). In spiritual terms, often describing how food impacts Muslims’ life. “…and He [God] who gives me to eat and drink” (The Quran, 26:79).

Food also has different meanings according to whether or not Muslims are allowed to eat the served food. Islam offers teachings on preparation and consumption of food. “And eat of what God has provided you, lawful and clean, and fear God in whom you are believers” (The Quran, 5:88). Muslims eat halal (as defined in Chapter One halal means that the food has been blessed and permitted. Prohibited foods are called haram).

Forbidden to you are carrion, blood, the flesh of swine, that over which name of other than God is invoked, the strangled, the beaten down, that fallen to death, the gored, and that devoured by beasts of prey [excepting that which you have duly slaughtered] and that sacrificed on altars, and that you seek to divide by the divining arrows; that is transgression. However, if any is constrained by hunger, without wilfully inclining to sin, then God is Forgiving, Merciful (The Quran, 5:3).

Modesty was another major concern for all Muslim women participants in this study, except for Huda. The Quran tells women to wear an outer covering and to draw their head coverings over their bosoms. Generally, Islam requires modesty in dress, with arms and legs covered. Clothes should be loose and the curves of the body should not be discernible, especially in public. However there is no one type of dress that is compulsory for all Muslim women. The form of the dress adopted varies from country to country. Participants’ stories bear witness to this. Yasamine’s story was a typical example how important was observing modesty for a Muslim woman when she is in the hospital and how Yasamine struggled to cover herself.

The importance of gender segregation comprised another major concern for the Muslim women participants in this study. Although participants came from different countries and there is considerable variation in degrees of segregation in the sexes in the different Islamic countries. The participants’ stories corroborate these findings, in particular, the
stories of Fariba and Marzieh refer to the stress of requiring segregation which should be observed in non-public interactions, including separation within adult hospital wards. Shakira believed it was generally appropriate for health professionals of the opposite sex to approach for conversational or other casual encounters, in particular in emergency situations, but this should be in a public context and not behind closed doors. Eye contact is frequently avoided, regardless of Islamic philosophy (Lawrence and Rozmus, 2001). Yalda and Sarah testify to this, as they did not look directly at me when speaking during interview. The interaction of men and women in Islamic societies is limited to the family unit and is explicitly defined by Islamic law (Al Shahri, 2002; Lawrence and Rozmus, 2001; Sheikh and Gatrad, 2001). Handshakes between non-related men and women are considered inappropriate according to Islamic law (Henley and Schott, 2003).

For the participants in this study, religion was fundamentally central in their everyday life. For example, Shakira related that religion plays an important role in her family. Spirituality and religious issues have been recognised by many authors as an integral aspect of comprehensive care (Puchalski, 2001). An understanding of the patient’s spirituality and religion, therefore, is integral to whole of patient care. When participants were talking to me about their religious practices, I was thoughtful how do health professionals address spirituality and religious issues during hospitalisation? It is important to discuss the issue of prayer with the patient.

Although most participants sought to maintain their normal prayer routines when they had been in the hospital, almost all of the participants asserted that hospitals had not made provision for Muslims’ prayer facilities (Hussein’s story testifies to this). Hussein said to me that he put a paper on the floor and prayed in the room occupied by some other patients because he found there was no Muslims’ prayer room in the hospital. Fariba suggested Muslim patients should be offered a clean and quiet room where they will not be disturbed. She added it is helpful to mark the Qibla [an Arabic word for the direction that should be faced when a Muslim prays] with an arrow. (Henley and Schott, 2003) also have recommended that health care facilities should provide two rooms, if possible, that men and women can pray separately. He suggested if there is only one room available, a curtain or screen could be used to ensure privacy between the sexes.
A crucial point to consider in reflecting on the needs of Muslim patients to undertake their obligations with regard to prayer, food, and modesty is their conception of illness or wellness. It is important because the notion that health and illness can be seen as distinct from the routine of daily life and religious observance is not possible for many Muslims. Muslims believe that illness and wellness is God’s will (Al-Hassan and S.M., 2005). They might use prayer to help them to cope with their hospitalisation. To be a good Muslim, to live Islam, is completely integrated into the experience of illness and hospitalisation. Although there is the possibility to compromise on these obligations the necessity to do so causes concern, even distress and the reality for the participants was to adapt to the situation and find ways of completing their obligations.

Islam is a worldwide culture, yet the findings demonstrate that many health care professionals know little about the culture as evidenced by the stories. For example, Hussein reported the agitation he felt when helped from the floor by a nurse who mistook the prayer position for a hospital fall. Given the dynamic multicultural nature of Australian society, this lack of knowledge of the cultural needs of Muslim patients may be a problem that is frequently encountered in Australian hospitals and would lead to a profound misunderstanding of culture that impacts on health care delivery. Hussein’s story refers to the misunderstanding between patient and health professional can lead to a tension between the cultures where the nurse saw him on the floor when he was praying and endeavoured to help him, but it made him agitated. Flores (2000) has described similar problems in the tension seen in health care services at the interface between the cultures of diverse groups and the hospital. This tension of culture is not as simple as good and bad, right and wrong, it is where misunderstanding come to the fore, rather than understanding.

A cultural tension, therefore, could be expected where merging of two ways of life, even in the hospital. The encounter between the predominantly Western health professionals and the Muslim patients in Australian hospitals is a meeting of two different lifestyles. Although health professionals are aware of the varied backgrounds of patients who come into hospital (Cioffi, 2006) and that the Muslim patients are no
exception, hospital regulations are created in response to the needs and expectations of the majority of population.

This kind of situation is not an inevitable event, but can be avoided if health professionals ensure the provision of care is flexible enough to incorporate the priorities and needs of the culturally diverse Australian community. This was seen in Yasamin’s story where the nurse provided towels and sheets to cover her as she liked. The flexibility in the planning of care may be even more important in multicultural societies such as Australia if the different needs of Muslim patients are to be met. Creating a cultural plan of care begins with understanding that care must be flexible to the cultural situation. Flexible care may mean a simple awareness of something different or developing tolerance and acceptance of a culture or religion is different from our own. Few Australian nurses are educated in how to provide cross-cultural care (Omeri, 1996) and scant resources are available to help.

It is beyond the scope of this study to provide simple answers and strategies to these many complex issues, the first activity for health professionals is recognising that these differences exist and having strategies to identify then incorporate these differences into the care that is provided. These interactions intensify cultural consciousness and awareness of the differences between the Islamic and Australian cultures, and also remind health professionals of the many commonalities. However, Muslims are in themselves a diverse culture, varying by race, language, and the degree of their religious conservatism. This diversity among Muslims is evident in the differences in styles of clothing, preferences for food and drink, traditions and customs. This diversity represents another challenge for Australian health system attempting to meet the needs of Islamic patients and highlights the importance of individualising care.

There is to date no Muslim model of nursing care in the literature and little has been written on the development of a theoretical framework of caring from an Islamic perspective. However, I contend that nurses can begin to consider such a framework in two ways. Firstly, nurses may consider basing care on a better understanding of certain beliefs, dynamics, and customs that greatly influence the lives of Muslims. Secondly nurses may explore individual issues related to life style and health of the Muslim
patient. The study shows that care can be enhanced by knowing the patient’s cultural and religious practices they would like to continue in the hospital.

Participants’ stories provided information about core Islamic culture. This information may be helpful when providing care to Australian Muslim patients. My overall intent is to enhance the ability of healthcare professionals to provide more culturally informed care, while never forgetting the “dynamic and even-changing nature of cultures that occur within cultural groups” (Tervalon, 2003, p. 572). For example, keeping in mind that each Muslim patient is a unique individual with her/his own personal beliefs and practices.

8.4. Implications and Recommendations

This study provided a rich interpretation of the meaning of hospitalisation to Muslim patients, attributed to their experience and what it meant to be a Muslim patient in non-Islamic hospitals. Interpretive inquiry does not lend itself to generalisation. However, the implications for practice that have arisen from the Muslims’ experiences in this study may be significant and resonate in regard to similar minority populations. Although the implications detailed here relate to health professionals much of the discussion is directed to nurses specifically. This study, however, is not about nursing practices. It is about how an individual experiences their hospitalisation as a Muslim patient in a non-Islamic hospital. This study does not set about to make judgments on health professionals’ practices. I am aware of the criticism of (Barkway, 2001), who argues that there has been a tendency for nurses, when undertaking phenomenological studies of the experiences of patients, to focus on the nurse and thereby fail in their purpose. However, the suggestions that I am about to make are drawn from the interpretation of the participants in this study.

The findings of this study provides unique insight for planning and implementing appropriate health care service and adding significant evidence on which to base nursing
practice and education that should be enhanced by further research. This section discusses these implications and provides a number of recommendations aimed to improving nursing practice.

The increasing numbers of Muslim patients require health professionals to broaden their knowledge of Muslim patients. In a twenty-first-century context, with globalisation, fast, easy travel, increased migration, there is an increase in minority groups living in already well established societies with different cultural and religious traditions. Although this study relates to Islam, the principles can be relevant to other different traditions.

This study draws a holistic picture of Being a Muslim patient in non-Islamic hospital, to provide health professionals with the opportunity to understand the experience and relate it to practice. Participants’ voices, therefore, are added to help guide practice.

The findings of this study suggest that Muslim patients cultural needs are important to them, yet are often not met. In order to meet these needs nurses require knowledge about Islamic cultural practices. As nurses comprise the largest group of health professionals, they are well placed to develop and sustain meaningful culturally sensitive relationship-centred care with Muslim patients.

The study showed that certain experiences of hospitalisation such as the disruption of normal lives and Being-thrown-into-an-un-everyday-world were shared among participants. Although these insights are not new (Holloway, Smith, and Warren, 1999), this study helps to put them in context and encourages health professionals to extend their knowledge about Muslim patient beyond a disease-centred perspective to a culturally focused person-centred perspective.

This study identified that participants felt they were in a strange place which differed with their everyday and familiar world. The findings suggest that it is imperative that health professionals are aware of the impact that hospital environment can have on patients from different cultural backgrounds. The study highlights the need for health professionals to consider the diverse needs of patients from different cultural
Findings from this study expand the health professionals’ knowledge of Muslim patients’ hospitalisation experiences and can potentially influence the care Muslim patients receive in non-Islamic hospitals. Participants in this study had much to say about hospital services for Muslim patients, such as dietary requirement, privacy, same gender care givers, and prayer. The study showed that Muslim patients found it beneficial when services were culturally sensitive for them and they suffered when it they were not. The study also showed that Muslim patients struggled to access appropriate services. Many participants worked to adapt to their circumstances and in some cases were assisted by health professionals which was appreciated. This study meaningfully informs nursing practice by providing valuable evidence on which to base future care.

Finally, this study has highlighted that Being a Muslim patient in a non-Islamic hospital is a challenging experience where two different cultures and lifestyles meet. The findings suggest that there are many aspects that need further consideration in providing care to Muslim patients. The study shows that for some participants Being a Muslim patient may stimulate profound feelings of loneliness and Being an outsider. This experience was not merely an unpleasant state but a situation of considerable gravity which requires serious consideration by health professionals to provide culturally sensitive care. The path is one where recognition that religious obligation is a goal that is central to a Muslim patient particularly in time of illness is required and that it can be achieved through knowledge, understanding, and cooperation.

The findings from this study provided valuable information and knowledge for those involved in the care of Muslim patients. The findings also represented possible areas for further research.
8.5. Recommendations for Further Research

This study suggested that there are many aspects of the care of the Muslim patient that require further consideration. Any research endeavour that seeks an increase in understanding and awareness of Muslim patients needs is helpful as many potential research directions exist. The following topics may provide additional insight into the nature of caring Muslim patients. These include:

- Because of diversity of Muslims living in Australia in terms of ethnicity/country of origin, Australian born or migrants from around the world, and where they are located, urban and rural environments there is certainly scope to replicate the study with a broader focus on participants. In addition, the setting of health care experience could be expanded outside of the confines of hospitals.
- The potential parallels with other cultural and religious minorities calls for replication of the study with these groups.
- The experience of health care providers who care for or have cared for Muslim patients is important to consider. Therefore it would be helpful to hear the stories of health professionals.
- The conduct of this study raised a number of issues where the overall approach and some methods needed to be adapted to be culturally acceptable to this particular group of participants. There should be further exploration and debate about this issue particularly.
- Based on the findings, there is potential to explore specific strategies to alleviate the feelings of Being an outsider. Potential research approaches include action research; working collaboratively with Muslim to ensure their hospital experience meet their needs.
- Other areas that may need a focused approach include the Muslims specific needs such as dietary requirement, gender segregation, privacy and prayer as they are included in the experience of the participants in this study.
- The final recommendation is for studies to develop a conceptual framework at both cultural and individual levels that more readily reflects the needs of Muslim patients.
In conclusion, research studies with Muslims patients are needed to uncover, develop and evaluate methods of care delivery that improve care to this group of patients.

### 8.6. The Unique Contribution of This Study

Much has been written about individuals from minority groups when they are found within a context that disrupts their normal pattern of Being. For most individuals simply being in hospital is a departure from their everyday life. In the case of minority groups and indeed Muslims it is recognised that certain needs may not met due to some aspects of this changed circumstance. For Muslims, certain needs with regard to food, modesty and prayer have been well documented. These issues were apparent in the findings of this study also. This represents a contribution to knowledge in terms of confirming previously reported findings. However the unique contribution that this study provides is found in both the depth and magnitude of certain phenomenon reported elsewhere and indeed new findings not uncover in other investigations. In examining the themes and sub-themes, again and again the centrality of religion for the participants is core to understanding their experience. Even those participants that do not strictly follow all the observances and practices of the Muslim faith, for example Huda, define their experience in the hospital in relation to Islam.

Being-thrown-into-an-un-everyday-world goes beyond simply being in an unfamiliar territory. It is the experience of Being drawn to profoundly re-consider your place in the world in a way that had not occurred for the participants previously and for some would alter their view well after hospitalisation had finished. In considering living-Islam-in-the-un-everyday-world again the centrality of faith is core to understanding the experience of the participants. The need to undertake observances and practices of the faith is not something that can be easily shelved or postponed until after hospitalisation. Even though Islam allows for exceptional circumstances, having to compromise on these aspects of faith caused great distress among the participants. This is particularly important to consider in light of the fact that in some cases the response was to
withdraw and be silent making it even more difficult to address the issues. However the stories of the participants demonstrated that there was an alternate approach for the participants, adapting-into-the-un-everyday-world. This finding illustrates the potential of taking a positive and pro-active approach to living-Islam-in-the-un-everyday-world where the challenge is best to met in a spirit of co-operation.

This study makes an important contribution in that it draws attention to some of the specific issues involved in investigating Muslims using method that, without some modification, may be deemed culturally in appropriate. Interviewing with family members present and considering the gender of the researcher being obvious examples.

It should also be considered that the contribution of the study goes beyond the individual elements that constitute the findings. This study has brought to light a deep ontological understanding of the research question. This study provides a rich ontological interpretation, rather than a mere discussion of the lived experience of the phenomenon, underpinned by the philosophical hermeneutic of Heidegger (1967/1996) and Gadamer (1989) as well as the ideas of van Manen (1990/1996).

**8.7. Conclusion**

This study reinforces the value of hermeneutic phenomenological research that aims to explore the experience of Being a Muslim patient. The findings of this study have provided insights into the world of Muslim patients. The challenge of living Islam in a non-Islamic hospital as experienced by the participants is one of Being-thrown-into-an-un-everyday-world which compels one to consider oneself and Being in the world. This brings recognition of being the same as others in that environment but also being different in a fundamental way that has a significant impact. For these Muslim patients the centrality of their religion means that they have the need to live Islam in this everyday world, where the environment presents hindrances to achieve this. The challenge is met by adapting to the environment to find ways of Being a Muslim.
The participants recognised that where this was successful was when those who control the environment were able and willing to assist in the process. It is my hope that other health professionals who read this work can appreciate and be informed by the interpretations presented in the two themes. This study has helped me to understand the experience of Being a Muslim patient in a non-Islamic hospital. In conclusion, I leave the reader with this thought:

Health professionals who care for Muslim patients need to be aware of, and not underestimate, Islamic lifestyle and its importance in Muslim’s life. When health professionals are unable to provide for Muslims’ needs, this must not distract from attempts to facilitate care for the Muslim patient. The hospital environment should be a place for Muslim patients to live as Muslim, not just as a place in which to survive.

I trust that the findings from this study contribute towards this aim.
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APPENDICES
APPENDIX ONE

KEY PERSONELL INFORMATION SHEET

Title of the study:
The experiences of Islamic people during hospitalisation in Australian hospitals: a phenomenological study

Researcher:
Rahayem Mohammadi, PhD candidate, Department of Clinical Nursing, University of Adelaide

Purpose of the study:
The study is being conducted to explore the experience of individuals from an Islamic background as a patient in an Australian hospital. The purpose of the study is to describe and understand the experiences of Muslim patients in a non-Islamic hospital.

Possible benefits from this study:
The findings of the study will be used to provide information that will influence health care practice to help ensure it meets the specific needs of this cultural group. The findings of the study will be the first step in understanding the experiences of Muslim patients, and as a result of this process help determine issues of importance for these people.

Your involvement:
The purpose of this request is to ask if you know or come across people from an Islamic background, who are going to be, or have been recently a patient in an Australian non-Islamic hospital, that you might provide them with a copy of the attached information sheet outlining the details of this study. If they express an interest or willingness to participate in this study, could you ask them to give you their name and a contact phone number. It would be appreciated if these details are collected, if you could either forward them to me at the address below, or contact me on the telephone number below so I can arrange to collect the information.

Rahayem Mohammadi
Department of Clinical Nursing
The University of Adelaide
SA 5005
Telephone (08) 8202 4158

If you wish to discuss any aspect of this study with someone not directly involved in the research, you can contact Dr Michael James, Chairman of the Royal Adelaide Hospital Ethics Committee, at (08) 8222 4138.

Thank you for your assistance in this process.
APPENDIX TWO

PARTICIPANTS INFORMATION SHEET

Title of the study:
The experiences of Muslim people during hospitalisation in Australian hospitals: a phenomenological study

Researcher:
Sadrul Bhabha, PhD candidate, Department of Clinical Medicine, University of Adelaide

Purpose of the study:
This study is being conducted to explore the experiences of individuals from an Islamic background who are patients in an Australian hospital. The reason for this study is that very little is understood about the Muslim's experiences and feelings during hospitalisation. The Muslim population is one of the minor's groups in Australia and so identifying their experiences of hospitalisation is an important issue for health care providers to understand.

Possible benefits from this study:
To you:
You will not benefit directly from this study, however, the findings of this study will provide valuable insights into the experience and therefore, inform health providers about important issues. Future care may be improved through these insights and may improve service to Muslims.

To the Health System:
There is potential that the findings of the study will be used to provide information that will influence healthcare practice about the specific needs of Muslim people during hospitalisation. The findings of the study will be the first step in increasing the awareness of Muslim cultures, and as a result of this process, help determine issues of importance for these people.

Your involvement:
If you agree to participate, the researcher will contact you to arrange an interview(s). The interview will be conducted at your convenience. Please let the researcher know if you cannot attend.

Confidentiality:
All information and documents containing your personal data will be kept confidential in our reports or publications, which will produce how the research. No information that could identify a particular individual will be made public.

Volunteering:
Your participation in this study is voluntary. You have the right to withdraw from the study at any time without any penalty to you or any action in the future.

Contact details:
The researcher can be reached via the following. If you wish to discuss your involvement in this study, or have any other questions, you can contact the researcher at any time.
Researcher: Sadrul Bhabha, PhD candidate, University of Adelaide
Telephone: (08) 832 0158 (office) / 0432220158 (mobile)
Email: sadrulbhabha@adelaide.edu.au

If you wish to discuss any other aspect of the study, with someone who is not directly involved, you may also contact the Chairperson, Research Ethics Committee, Flinders University, on 8222 4788.

Thank you for your assistance.
APPENDIX THREE

Patient Information Sheet (Farsi version)
APPENDIX FOUR

ADVERTISING FLYER

Are you interested in a research study about Muslim patients in hospital?

I am looking to recruit people from an Islamic background who have previously been admitted to hospital to become a participant in a research project.

Project Title: The experiences of Islamic people during hospitalisation in Australian hospitals: a hermeneutic phenomenological study

Researcher: Nousedin Mohamed, PhD candidate, Department of Clinical Nursing, University of Adelaide

Purpose of the study: This study is being conducted to explore the experiences of individuals from an Islamic background as a patient in an Australian hospital. The reason for this study is that very little is understood about the experiences and feelings of Muslims during hospitalisation. This information will help improve health services for Muslims in the future.

I am looking for people who have the following specific criteria:

• You are a Muslim
• You are aged more than 18 years
• You have been admitted to hospital on at least one occasion in the last two years

If you are interested and think you may be eligible for this study or know someone else who may be interested
Please contact me:

Nousedin Mohamed
Telephone: (01) 8303 6166 (week) or 91223-6165 (mobile)
Email: nousedin.mohamed@adelaide.edu.au

Thank you for your assistance.
پرگاره اطلاعیه دعوت به همکاری

با تیم‌های خود، از مطالعه‌ای در رابطه با بیماران مسلمان در پی‌رسانه‌های غربال‌گذاری
شرکت می‌حلو.

بستن دریاچه به منظور کاهش شاخص‌های سلامتی
بین‌المللی، شرکت مطرح کرده‌است.

حرارت تهیه، توزیع در دو دسته می‌باشد. می‌توانیم‌با استفاده از هر دو مدل، هرکمکی‌ای که می‌توانیم به شما ارائه دهیم که مطمئن بودیم، باشد.

محول: نوریا اکرمی، داشنه، داشنگه، ایلام

امکان‌های تحقیق، این مطالعه بیشتر در اکثریت مناطق مختلف و بیشتر در بخش غربال‌گذاری موثر بوده‌است. این امر با داشتن اختلافات اجتماعی و گسترش و تغییرات، جمعیت‌ها به‌همراه مسلمانان در حوزه یکپارچگی و یکپارچگی دستگاهی و ایالتی، که این دو مدل شامل پیکر و تکلیف از فهرست خاص بشری است که به‌صورت جداگانه، و مسابقه بزرگه‌ای در محصولات انواع آن‌ها، ممکن است باشد.

برای اطلاعات بیشتر، لطفاً به دفترچه این مقاله، نگاه کنید.

کامبیز یاری

آدرس پست الکترونیکی: naoredo.mohammadi@adelaide.edu.au

حقه‌ها شما همان شکل را دارم.
APPENDIX SIX

15 July 2004

Mr N Mohammadi
DEPT OF CLINICAL NURSING
UNIVERSITY OF ADELAIDE

Dear Mr Mohammadi,


I am writing to advise that ethical approval has been given to the above project. Please note that the approval is ethical only, and does not imply an approval for funding of the project.

Research Ethics Committee deliberations are guided by the Declaration of Helsinki and NHMRC National Statement on Ethical Conduct in Research Involving Humans. Copies of these can be forwarded at your request.

Adequate record-keeping is important and you should retain at least the completed consent forms which relate to this project and a list of all those participating in the project, to enable contact with them if necessary, in future. The Committee will seek a progress report on this project at regular intervals and would like a brief report upon its conclusion.

If the results of your project are to be published, an appropriate acknowledgment of the Hospital should be contained in the article.

Yours sincerely,

Michael James
DR M JAMES
CHAIRMAN
RESEARCH ETHICS COMMITTEE
CONSENT FORM

Project Title: The experiences of Islamic people during hospitalisation in Australian hospitals: a hermeneutic phenomenological study

Researcher: Noordeen Mohammadi

1. The main aim and purpose of the research project has been explained to me, I understand it, and agree to take part.

2. I understand that I may not directly benefit from taking part in the trial.

3. I understand that while information gained during the study may be published, I will not be identified and my personal results will remain confidential.

4. I understand that I can withdraw from the study at any stage and that this will not affect my medical care, now or in the future.

5. I have had opportunity to discuss taking part in this investigation with a family member or friend.

Name of participant:
Signed:
Date:

I certify that I have explained the study to the volunteer and consider that he/she understand what is involved.

Signed:
Appendix Eight

Consent Form (Farsi version)

هم موافقت به همگانی

طراحی تحقیق، خورشید، مرکز مطالعات در حوزه پرستاری در بیمارستان‌های ایران باید، مطالعه پژوهش kształتی

محلی برای ورزش دویدن، داشته باشد که گروه تمرینی داشته باشد، خانگی و کارکرد.

1. ماهیت و آنفولانس تحقیق برای من یوبنچ ۶۸۱۴ شده، من از ماهیت و آنفولانس تحقیق آگاه و توانایی به همگانی دارم.

2. من بهتر همکاری با شرکت در صورت حساسیت شدن خود در مطالعه می‌کنم. ما فعالیت‌های شخصی من بیماری‌ها نمی‌پذیرفته و تحقیق از بیماری‌های شخصی من بیماری‌ها نمی‌پذیرفته و تحقیق از بیماری‌های شخصی من.

3. اگر همکاری شهروندی خود من به تحقیق یا همکاری از بیماری‌های شخصی من بیماری‌های شخصی من

بیماری من از روی این‌جا که من از روی این‌جا که من

بیماری من از روی این‌جا که من از روی این‌جا که من

4. من فراموشی می‌کنم یا نوره از روانی و مهربانی به همگانی و سطح ویژه که من از روی این‌جا که من

5. ام اعضا

6. کروک

اینچک که از روی این‌جا که اطلاعات من به همگانی با کمک به شرکت غذاهای طبقه با مطالبه داده شد و نیز

استفاده

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**NOTE:** This publication is included on pages 240-244 in the print copy of the thesis held in the University of Adelaide Library.

It is also available online to authorised users at: