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Hospital food: When nurses' and ethnic minority patients' understanding of Islamic dietary needs differ

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Abstract

Aim: The aim of this study was to investigate how medical unit nurses assess their knowledge about Muslim patients' dietary preferences and needs and Muslim patients' needs regarding food.

Design: Mixed-method design.

Methods: Two-part study. Part 1: Two focus group interviews and a survey answered by medical unit nurses. Part 2: In-depth interviews with ten immigrant patients (eight Asians and two Africans). Hermeneutic analysis of qualitative data and SPSS were used for descriptive analysis of the quantitative data.

Results: The nurses' knowledge about acceptable and prohibited food within Islam appears to be simplistic and Muslim patients tended to be perceived as a homogenous group. Patients' distrust about the preparation and content of the food served may result in insufficient nutritional intake. Serving food that is acceptable to individual patients requires insight and is an essential part of culturally sensitive nursing care.

KEYWORDS

culture, diet, hospital food, intercultural nursing, religion

1 | INTRODUCTION

According to the Universal Human Rights, equal health care should be offered irrespective of patients' religion, culture or ethnicity (WHO, 2002). Equal health care entails universal access to services of equally good quality that are also tailored to patients' individual needs. For patients with different needs and circumstances, *true equality* is facilitated through differential treatment adjusted according to, for instance, cultural and religious backgrounds (Djuve, Sandbæk, & Lunde, 2011). Hence, to ensure that ethnic minority patients receive equally good care, dissimilar treatment may be needed. Thus, healthcare personnel must be able to assess whether and when dissimilar or special treatment is needed. As nutritional status and dietary intake are essential for recovery after disease and malnutrition is common among hospital patients (NCC-AC, 2006), it

is particularly important for nurses to be knowledgeable about these areas.

Just having to be admitted to a hospital can be stressful enough, but the additional stressor of being served food that is unfamiliar, unappetizing and/or not in accordance with cultural and religious requirements can exacerbate any discomfort. Serving ethnic minority patients a diet that is acceptable according to their cultural and religious mores is important for providing culturally sensitive nursing care and is necessary for establishing trust between ethnic minority patients and healthcare personnel (Alpers, 2017).

What substances are considered food and what are not vary widely throughout the world. Food items that are eaten in one society or group may be rigorously forbidden in another (Helman, 2007). What foods people eat may be guided by religious and cultural norms and taboos, and medical philosophies. Class, social status, gender,

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age, education, employment, economic status, personality and taste also can be deciding factors (Fieldhouse, 1992; Helman, 2007), some of them sustaining and confirming cultural identity (Kocktürk, 1995). Hence, many factors influence people's food choices.

Cultural competency is the pillar of intercultural nursing care (Alpers, 2017). This concept is expressed through *cultural awareness* (Campinha-Bacote, 2007; Papadopoulos, 2006; Ramsden, 2002), *cultural knowledge* (Campinha-Bacote, 2007; Papadopoulos, 2006) and *cultural skills* (Campinha-Bacote, 2007), which constitute the theoretical framework for this paper. *Cultural awareness* within the field of nursing means being conscious of one's values and perceptions, and has been described as fundamental to the development of cultural competency among nurses (Campinha-Bacote, 2007; Papadopoulos, Tilki, & Ayling, 2008; Ramsden, 2002). To develop cultural awareness, a person needs to become aware of his or her own stereotypes, prejudices and preconceptions about those who are different, including preconceived notions about what foods various groups of patients—in this case, Muslims—may or may not eat. A lack of cultural awareness constitutes the most serious barrier to culturally competent treatment and care (Campinha-Bacote, 2007).

Cultural knowledge is described as “the process of seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups” (Campinha-Bacote, 2002; p. 182). Awareness of intracultural variations—that is differences within ethnic groups—is also important. Furthermore, one must realize that cultures are constantly changing and that healthcare personnel cannot be knowledgeable about every cultural and/or religious group's attitudes towards health and healthcare practices. Thus, healthcare personnel need to learn to collect cultural data relevant to each individual patient, and to assess his or her condition in a culturally sensitive way. This is described as *cultural skills* (Campinha-Bacote, 2007).

The goal of cultural assessment is to elicit information from patients that will enable healthcare providers to understand each patient's problems and formulate a culturally relevant treatment plan that is acceptable to both parties (Campinha-Bacote, 2007). Challenges concerning cultural and/or religious dietary requirements are in this paper used to illustrate the need for cultural competency among nurses and other healthcare personnel.

Food culture is a term used to describe the non-nutritive, yet nonetheless significant, aspects of food, such as when food is eaten and how it is served (Clark et al., 2010). People tend to take their food habits with them when they migrate. Although they may incorporate new dietary habits (Edmonds, 2005), food habits are often among the last cultural practices to change (Kittler, Sucher, & Nelms, 2012).

Helman (2007) differentiated between “sacred” foods that are “validated by religious beliefs” and “profane” foods, which refer to “foodstuffs expressly forbidden by the religion ... This latter group is usually the subject of strict taboos that not only prohibit ingestion of the food, but also forbid physical contact with it. In most cases, this profane food is also seen as unclean and dangerous to health” (p. 53).

Examples of profane foods within Islam are pork or pork-based products and food containing blood or entrails. Such products are *haram*, or unclean and forbidden under Islamic law. Conversely,

sacred food, which is food that follows the Muslim dietary code, is called *halal*. This code requires that meat be slaughtered in a ritually correct manner. Meat from cloven-hooved animals and fish with scales and fins are permitted (Helman, 2007).

Besides food habits, preferences and tastes that are at odds with the food served in hospitals may influence patients negatively and reduce their appetite during their stay in the hospital (Stanga et al., 2003). When coupled with uncertainty over whether the dishes served are in compliance with Islamic dietary rules, Muslim patients are particularly vulnerable to undernutrition, a problem that “affects 30%–50% of [all] adult patients admitted to hospitals in Western countries, and is associated with increased mortality, morbidity, length of stay, and costs” (Thibault et al., 2011, p. 289).

The literature on cultural knowledge is, to a large extent, theoretical, while the more concrete literature on food and diet is related to cultural competency only to a limited extent. A contribution of this paper is that these two areas have been integrated. In addition, data from both nurses and ethnic minority patients were used to comparatively evaluate their understandings, which is an approach to intercultural nursing issues that I have not found used elsewhere.

As most of the interviewed patients in this study were either Muslims or spouses of strict Muslims, the focus in this paper is on nurses' and patients' disparate understandings of Muslim dietary prescripts. Hence, the research question is as follows: What knowledge do nurses have about Muslim patients' religious dietary needs and preferences, and what needs and beliefs do Muslim patients have concerning food?

2 | METHOD

In this paper, I present findings from a larger study conducted in an inner-city hospital in Oslo, Norway, where 30%–40% of the patient population hails from non-Western countries, many of whom are Muslim. Since ethnic minorities are generally under-represented in clinical research (George, Duran, & Norris, 2014), and little research has been conducted in which both nurses' and ethnic minority patients' perspectives are discussed, it was important to find a way to study both parties' viewpoints. This provided insight into the reciprocal perceptions of the two parties, not the least of which were patients' views on what knowledge the nurses are lacking. Therefore, the research was conducted as a two-part mixed-method study:

2.1 | Part 1. A self-reporting study on medical unit nurses' competency working with non-Western patients

2.1.1 | Focus group interviewees

Two focus group interviews—one with six and the other with five group members—were conducted with RNs working in the hospital's medical unit. Participants were recruited through information provided at unit staff meetings. Those interested in participating in the study put their names on a designated list. None of these participants were Muslim.

Besides information about participants' hands-on experience working with ethnic minority patients, the focus group discussions helped operationalize the term *cultural competency*.

2.1.2 | Data analysis

The recorded interviews were transcribed verbatim and analysed in the hermeneutic tradition.

2.1.3 | Questionnaire study

Some instruments for mapping healthcare personnel's self-assessments concerning cultural competency already existed (Campinha-Bacote, 2007; Sargent, Sedlak, & Martsof, 2005). However, the factors examined using these instruments were only found, to a small extent, to be clinically relevant to nurses working in a medical unit context. In the two focus group interviews, participants were asked what issues would be important to cover in a questionnaire. These interviews, together with informal talks with several experts within various areas of interest, constituted a first step in the development of a Likert-type questionnaire (Halkier, 2010).

The questionnaire was discussed with a professor specializing in questionnaire studies before it was piloted by two college teachers experienced in nursing research and two nurses working in the medical unit in the hospital. The four pilot-study participants responded and commented on the questionnaire, which caused a few linguistic simplifications and the removal of a couple of statements perceived as repetitive.

The final version of the questionnaire consists of 35 statements. Each statement was given six response alternatives: 1–2 = I strongly agree/agree, 3 = I neither agree nor disagree, 4–5 = I disagree/strongly disagree, 6 = I don't know. Additionally, there were four open-ended questions. This present paper is centred around the topics *culture*, *religion* and *diet*. Five questions focused on hospital food, and four of them are included in this paper (the last one was about Jews, Hindus and Buddhists). Some of the questionnaire's other topics are discussed elsewhere (Alpers & Hanssen, 2014; Hanssen & Alpers, 2010a, 2010b).

2.1.4 | Questionnaire respondents

$N = 145$, 90% of nursing staff (12% men, 88% women). The respondents' nursing experience ranged from months to more than 10 years (mean: 5.9 years). As the medical unit always has several immigrant inpatients, all the respondents had experience working with this patient group. Also, these respondents were recruited through information provided at unit staff meetings.

2.1.5 | Data analyses

The quantitative data were analysed using SPSS statistical software (version 23), with the questionnaire statements used as analytic categories. The recorded focus group interviews, responses to the

questionnaire's four open-ended questions, and comments made in the margins were meticulously transcribed. The questionnaire statements also were used as thematic analytic categories for the qualitative data analysis.

2.2 | Part 2. An interview study of non-Western patients

2.2.1 | Inclusion criteria

(a) first-generation Asian or African immigrants, (b) at least 18 years old, (c) must be patients in the hospital's medical unit, and (d) mentally and linguistically able to be interviewed. The patients included could not have any cognitive or speech impairments. Knowledge of Norwegian was not a requirement, as interpreters were used when needed.

2.2.2 | Interviewees

Six women and four men, aged 32–85 (mean: 55 years), who have lived in Norway for between six and 40 years, agreed to participate in the study. The interviewees were recruited by members of the medical unit's nursing staff.

Eight interviewees hailed from various parts of Asia, and two were from sub-Saharan African countries. An interview guide was used, and hospital food was one of the topics. Eight patients, including seven Muslims and one Christian who cooked for her strictly religious Muslim husband, talked about their adherence to a Muslim dietary code.

2.2.3 | Data analysis

The recorded interviews were transcribed verbatim and analysed in the hermeneutic tradition according to Kvale and Brinkmann's (2009) three "analytic contexts", or levels: (a) Self-understanding: *What is this interviewee saying concerning hospital food in an immigrant-patient context?* (b) Critical understanding based on common sense: *How do I understand what is being said?* (c) Theoretical understanding: *How may this be interpreted in light of theoretical knowledge?* These levels often overlap during the analytic process.

Although the two parts were analysed separately, a hermeneutic analytic approach was used in both sets of qualitative data. The rationale for this approach was that there were qualitative data transcribed into text in both parts of the study (focus group interviews and the questionnaire's open-ended questions and comments in Part 1; the individual interviews in part 2), and the subject matter of hermeneutics is primarily text. Polit and Beck (2017) point out that hermeneutic inquiries mainly focus on meaning and interpretation—how "individuals interpret the world within their given context" (p. 465). As the purpose of the project was to learn about the interviewees' experiences, attitudes and perceptions, hermeneutics was the natural methodological choice.

To avoid researcher subjectivity (Polit & Beck, 2017), the author and a co-analysers read the interviews separately before

discussing the data and agreeing on the results. Analytic credibility was obtained by presenting quotations from the interviewees' descriptions of their own thoughts and experiences. Dependability was obtained through those experiences and feelings that show commonalities, and individual variations (Polit & Beck, 2017).

The research methods were chosen to compare nurses' and ethnic minority patients' understandings of pertinent issues about cultural competency.

2.3 | Ethical considerations

Both parts of this study were approved by the hospital's privacy ombudsman for research, and by the unit head. All the participants received oral and written information about the study and its purpose. The participants also were informed that participation was voluntary and that they were free to withdraw from the study at any time. The patient interviewees signed a consent form after being presented with this information.

The interview recordings were deleted after transcription. The transcriptions were stored according to ethical research guidelines (The Norwegian Directorate of Health, 2009) and will be deleted when the project is concluded. The participants' confidentiality was ensured throughout the entire research process.

2.4 | Critical comments

The questionnaire concerned the nurses' self-reported competencies, that is their subjective viewpoints. However, Fernandez et al. (2004), among others, have found that self-assessed competency studies are relatively trustworthy.

Although no other measurements were used, the validity and reliability of the quantitative part of the study were secured through the fact that it was a small pilot study and that the questionnaire was assessed by a specialist on questionnaire development.

TABLE 1 Medical unit nurses' general evaluation of the food offered to ethnic minority patients and their knowledge about what Muslims may or may not eat

	Patients with ethnic minority backgrounds are offered food according to their faiths and cultures (%)	I have adequate knowledge about what Muslims may or may not eat (%)
I strongly agree	57	22
I agree	24	35
I neither agree nor disagree	8	23
I disagree	4	11
I strongly disagree	1	7
I don't know	6	1
Total	100	99*
N	143	144

*As decimals are not given, the percentage is 99%.

TABLE 2 Medical unit nurses' general evaluation of whether Muslim patients liked the halal food offered

	All Muslim patients at this hospital like the halal food they are served (%)
I strongly agree	4
I agree	12
I neither agree nor disagree	13
I disagree	6
I strongly disagree	18
I don't know	47
Total	100
N	145

Questionnaire respondents were anonymous. Hence, focus group participants filled out the questionnaire. As the study's focus was on respondents' personal views about the questionnaire's statements, this does not negatively affect the validity of the study.

Permission to collect data on participating nurses' religious backgrounds was not granted.

The 10 in-depth interviews with Asian and African patients produced rich descriptions of the interviewees' various experiences while in this specific hospital's medical unit. Although their experiences and views varied, there was a definite pattern in the perceptions expressed that indicates adequate data saturation.

3 | RESULTS

While the nurses reported an adequate, yet limited, understanding of the religious, cultural and individual aspects of food, the patient interviewees painted a complex picture of dietary imperatives and individual meanings of food.

3.1 | Nurses' assessments of their competencies

Eighty-one per cent of the medical unit's nurses agreed or strongly agreed with the questionnaire statement that ethnic minority patients are offered food according to their faith and culture, and 57% agreed or strongly agreed that their knowledge about Muslim dietary requirements was adequate (Table 1). In addition, the focus group interviews indicated that the nurses assessed their knowledge about Muslim patients' dietary needs as adequate, though their knowledge mainly was limited to prohibitions on pork and an awareness of halal. A few nurses mentioned that some patients did not like overly spicy food, while others preferred Norwegian fish dishes. Even so, the nurses admitted that they tended to serve Muslim patients halal food without inquiring about whether this was what they preferred, or whether other individual food preferences were important to them.

Table 2 shows to what extent the nurses thought Muslim patients at the hospital liked the halal food they were served. While 24% of the nurses found that this was not the case, 47% did not know.

3.2 | Dietary customs as seen by patient interviewees

There were wide variations in patient interviewees' attitudes towards Islamic dietary rules and how strictly they followed them. As they found that the nurses were lacking in religious dietary knowledge, several interviewees, like this one, did not quite trust the food they were served, even when they were told that it was halal:

Everyone understands that Muslims don't eat pork, but everybody believes that it is just to remove the pork meat from the slice of bread and then, 'Oops, that was wrong. Here you are.' For them [the patients], it [the food] has become totally unclean. They cannot even touch the plate (A).

Since they were not in a position to verify whether the meat they were served was slaughtered and treated according to Islamic dietary rules, some chose only to eat foods they definitely knew were religiously acceptable. One Asian patient, for instance, would only eat bread and did not touch other foods. Another patient said she mostly ate fish to be on the safe side, while a third had "not eaten properly in five to six days" (B).

Other Muslim patients chose to trust the healthcare personnel's assertion that the dishes were halal. As one patient put it: "I ask, 'Is it chicken?' 'Yes, it is chicken.' 'OK, fine.' I don't ask, 'How is it slaughtered?' I don't ask that". (C). Another patient remarked, "I said that halal chicken was fine, so they served me a meal. It was halal chicken, done. In my opinion, I must not ask them, 'Is this halal?' If they say it is halal, no worries" (D).

To others, a halal diet was of no importance. As one female patient said, "I am much more liberal than all my family and friends. They would probably never eat bread with meat and such. They would choose jam and cheese". While some patients will not even eat cheese because it may contain pork rennin, this patient maintained that other Muslims were too demanding and made things too complicated: "Chicken, fish, lamb, or beef... if they ask, I choose among those, but if I am served pork and don't realize it, I'll eat it" (E).

Besides the question of whether or not to trust the dishes they were served, several patients found the hospital food to be very different from what they were used to. Although they generally accepted what was being served, they did not necessarily enjoy it: "Well, we were given food, and I did eat it. That was OK, acceptable. One has to endure. It is hospital food" (B). A Somali woman said she did not eat much because she did not like the food. She had, for instance, been served "fish balls", a common Scandinavian dish, which she found highly unappealing.

Most of the Asian patients were accustomed to several warm meals per day, and spicier dishes, in their regular diets: "In my opinion, the food should be hot. A little hot-tasting food, but that is not possible because there are different types of people. They make food with average taste, so it suits both you and me" (H).

The patient interviewees complained about too many meals based on bread, as this was found to be very monotonous: "Ordinary

slices of bread do not make one feel good. We only eat bread once a day, not three times a day" (F). Moreover, Norwegian breads are baked as loaves with yeast and are made with much less finely grained flour than most immigrants are used to. This rather dark bread is served as open-face sandwiches, which are very different from the naan, pita, etc., that tend to accompany meals in other parts of the world. However, most patients ate what they were served: "I am here, and I must eat the bread and the spread and cheese, even though it is very boring" (A). One of the African patients had, after 30 years in Norway, learned to accept that "this is how it is, potatoes and gravy and such for dinner, and then bread in the evening, lunch, and breakfast ... I wish there were more lentils and various beans and rice to choose from". Another African patient said: "We eat rice and chicken ... and spaghetti and bread and gravy, soup, different things, but here [in the hospital] we did not. But ... you cannot say that I don't want this and I want that; you just eat what they've got" (G). More fresh vegetables and fruit, paste, beans, etc., "would have been a little more interesting" (A).

3.2.1 | Special need of information

One of the Muslim patients pondered the differences between the information given in Norway and Pakistan about the administration of medicines and food. In Pakistan, she was accustomed to receiving precise instructions about what to eat or drink when taking her medicines. In Norway, she received no such instructions:

We may take [the medicines we are given here] in whatever way we want. We may, for instance, take them with water, while in Pakistan, we are told that this medicine you may take with water, this should be taken with milk, etc. ... If you take this medicine, you should not eat this type of lentils, and if you take that type of medicine, you may not eat porridge. ... There are different rules for what you may eat and not eat in relation to the medicines you take (F).

In the eyes of this patient, the lack of guidance about what to eat or drink when taking her medication amounted to inadequate information from healthcare personnel.

4 | DISCUSSION

A main finding in this study is the difference between the nurses' superficial understanding of the Islamic dietary code as "no pork" and the patients' quite varied and individual attitudes towards food and dietary preferences.

According to Kittler and Sucher (2004, p. 202), taste in its broader definition "includes numerous sensory properties that are more cultural than physiological. Color, aroma, and texture are equally important to what tastes 'good' to us". People's palates are trained, and taste and smell are subject to cultural control (Douglas,

1983). While one food aroma may stimulate the appetite, another may cause revulsion. Even though most of the Muslim patients appreciated being served a halal diet, the hospital food was found to be monotonous, and either too spicy or too bland. An Australian study showed that Afghani patients did not wish to be admitted to the hospital because they would miss their own cultural food (Henderson & Kendall, 2011).

Research shows that in an institutional setting, food intake can be enhanced by catering to cultural and individual food preferences (Buchowski, Sidani, & Powers, 2014). The fact that many patients have reduced appetites while in hospital (Stanga et al., 2003) makes serving food as close as possible to patients' tastes and cultural and/or religious needs imperative, and information about food habits and taboos needs to be part of data collection upon admission to the hospital. Collecting cultural data, according to Campinha-Bacote (2007), requires using cultural skills. However, the patient's dietary habits and nutritional status seem to be ignored in many admission interviews and assessments of hospital patients (Carz et al., 2012; Mortensen, 2006). This, although dietary regulations for hospitals in England, for instance,

...require that all religious, cultural and nutritional needs are to be met ... The application of the terms KOSHER and HALAL can only be applied to permitted animal products or their dishes that have been correctly handled throughout the food chain. When serving cultural meals, staff must be trained to food service standards akin to those applied to "allergy meals" so as to avoid unacceptable cross-contamination

(Carz et al., 2012, p. 80).

As seen in the results section, some Muslim patients will not eat meat that is normally permitted if they worry that it has not been slaughtered in the correct way. Others find it "sufficient to avoid alcohol and pork, which are important aspects of the code, and they will be satisfied to order from the regular menu" (Lawrence & Rozmus, 2001, p. 230). Although the majority of the nurses in the study reported that ethnic minority patients are offered hospital food according to their religious beliefs and cultures, many seemed to be lacking in cultural awareness within these areas although claiming to have knowledge about the Islamic dietary code.

Jhutti-Johal (2013) found that "healthcare providers often assume that ethnic minority groups are homogenous blocks of people with similar needs and fail to recognize that a diverse range of views and practices exist within specific groups themselves" (p. 259). This assumption was reflected in the present study. The findings clearly indicate a lack of awareness about the impact of cultural and religious backgrounds, and intracultural attitude variations, which Campinha-Bacote (2007) emphasized as being important in encounters with ethnic minority patients. According to the focus group interviews, the nursing staff tended to not check for possible individual nuances in food preferences among patients, nor what religious dietary rules were important to each patient. Thus, they neglected to collect

cultural data relevant for individual patients within this important clinical area. This corresponds with the questionnaire findings that found almost 50% of the nurses did not know whether their Muslim patients liked the halal food they were served. The nurses seemed to be unaware of the wide individual variations in tastes, attitudes and needs among these patients.

As seen in the results section, patients may worry that their meals could contain food prohibited by their religion or prepared in a way that makes it haram, for example meat from animals not slaughtered according to their religious code or that has been in contact with forbidden food items. This may cause distrust, and "appropriate labelling of hospital food is vital to help them feel safe and secure that whatever they are choosing does not contain any 'forbidden' ingredients" (Carz et al., 2012, p. 80).

Distrust of the preparation and treatment of food served in hospitals may lead to insufficient nutritional intake. If a patient hardly eats anything for 5 or 6 days out of fear that the food might be religiously unclean, as exemplified by one of the patient interviewees, this will lead to an insufficient intake of nutrients. Hence, distrust may lead to poor patient well-being (Betancourt & Renfrew, 2011), poor patient satisfaction (Cunningham, Sohler, Korin, Gao, & Anastos, 2007) and risk of harm to patient health.

Some of the interviewed patients' statements reflected a humoral understanding of health, as evidenced by the female patient who described how physicians in Pakistan would prescribe what food and drink to ingest with specific medicines. Often, people are unable to articulate their culture-based medical beliefs, the underlying principles of dietary choices and the combination of philosophies that influence them (Austveg, 1994; Hørthe, 2014). This may be tacit knowledge, but one may wonder whether Western healthcare personnel ever ask their patients about such things. In humorally oriented patients who expect to receive very particular dietary information, this may create distrust towards the physician.

Apart from the dietary rules set forth by the Quran, there is no "Muslim" medical system that includes a particular dietary philosophy. However, in many societies around the world, including among many Muslim groups, the aforementioned humoral approach is taken, that is balance is equated with health, and imbalance is equated with illness (Helman, 2007). Unani, a humoral medical system wherein the focus is on the balance between various elements or forces within the body (Hylland Eriksen & Sajjad, 2012), is an example of this. Unani medicine is adhered to by many Asian Muslims and may be practised alongside other medical systems, such as biomedicine, Ayurveda, or folk or tribal medicine (Sheehan & Hussain, 2002). Hence, the medical philosophy that a Muslim follows depends on his or her cultural, rather than religious, background.

Depending on what medical philosophy the patient has adopted, the understanding of the relationship between illness, treatment and nutrients may differ greatly between healthcare personnel and patients. Gathering data on patients' beliefs and attitudes will aid clinicians in dealing with issues related to conflicting beliefs and value systems (Kleinman, Eisenberg, & Good, 1978), such as what foods a patient who lives according to a humoral philosophy may either eat or avoid to regain his or her balance and, consequently, health. A thorough discussion

on health and diet is important because adherence to humoral balance principles while in a hospital may cause nutritional—particularly protein—deficiencies if there are important nutrients that a patient will not eat (Hanssen, 2010; Helman, 2007). As seen via the Pakistani patient who missed being told what to eat or drink when taking various medicines, lack of such discussions may cause patient confusion, and even distrust, in healthcare personnel and the treatments offered.

Purnell (2002) claimed that knowing how food and food substances are used in various cultures to treat illness and promote health and wellness is a central part of nurses' cultural competency, but being fluent in every culinary tradition is not realistic. However, some knowledge goes a long way towards promoting dialogue about food, nutrition and personal preferences and, through this, towards learning about patients' likes and dislikes, favourite dishes and foods they believe to be healthy in their current situations (Goody & Drago, 2009; Hanssen & Kuven, 2016).

5 | CONCLUSION

This study demonstrates the importance of nurses not only being knowledgeable about religious dietary restrictions, but also being culturally skilled enough to inquire about how strictly each individual patient wishes to adhere to these restrictions. If patients either do not trust the food they are served, or do not like it, or both, their nutritional status and health may seriously suffer.

This paper illustrates how important it is for health professionals to be aware of how religion and culture influence what foods a person may eat. Only the patients themselves know what core diet is important for their physical and spiritual well-being, and what their personal food preferences are. Serving food that meets patients' physical, social and spiritual needs requires insight and genuine interest, and is an essential part of patient-centred and culturally sensitive nursing care.

Rendering equal healthcare services irrespective of patients' religions, cultures and ethnicities, as required by the Universal Human Rights, often means that patients need dissimilar treatments. Assessing whether ethnic minority patients have dietary needs other than the majority patient population, and what these special needs may be, requires cultural awareness, cultural knowledge and cultural skills. It is important that hospitals do their utmost to offer patients food that is acceptable to them. Even so, it may be necessary to discuss how far it is possible to cater to individual patients' food preferences while in hospital.

6 | RELEVANCE TO CLINICAL PRACTICE

Serving patients food that is culturally and religiously acceptable to them is an important part of rendering equal healthcare services. This requires cultural competency. Caring for Muslim patients requires cultural knowledge far beyond that of "Muslims do not eat pork". Nurses need to assess how strictly each individual patient adheres to religious dietary guidelines. Cultural awareness, knowledge

and skills are needed to develop cultural competency and need to be focused on education, and on in-service seminars. Information about halal food in hospitals should be easily available to all patients, for example through brochures describing how meat is treated from slaughter to plate. This may help create and reinforce trust.

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CONFLICT OF INTEREST

None.

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