

Chaplaincy Services for Muslim Patients in New York City Hospitals:

Assessing Needs, Barriers, and the Role of Muslim Chaplains

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REPORT

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Executive Summary

RELIGION AND SPIRITUALITY are the first, and sometimes only, available sources of comfort for many hospital patients facing difficult events. Since chaplaincy is most commonly recognized as a Judeo-Christian practice, other spiritual perspectives receive less attention. This study assesses three areas: the existing chaplaincy care services available for Muslim patients in New York City hospitals, as perceived by chaplains and directors of chaplaincy departments; the different ways that Muslim and non-Muslim chaplains approach pastoral care and their methods of providing religious and spiritual treatment for Muslim patients; and the important roles Muslim chaplains play when serving Muslim patients in hospitals and other health care settings. This analysis of 56 pastoral care directors and 33 Muslim and non-Muslim chaplains provides information about the existing services available to Muslim patients in NYC hospitals, the approaches used in serving Muslim patients, and the roles that Muslim chaplains provide in health care settings.

Key Findings

THE MAJORITY OF PASTORAL care directors reported that their hospitals employed board-certified chaplains, while findings from the interviews indicated that only one-third of chaplains were board-certified (including one Muslim chaplain). This discrepancy may serve as evidence for the fact that hospital chaplaincy programs may not be capable of meeting the challenges of an increasingly diverse patient population.

Muslim chaplains' roles with the highest perceived importance fell into three areas: handling directive education and organ donation, prayer, and providing emotional support to patients and their families. One limitation of these results is the perceived roles of the Muslim chaplain differ based on location of the hospitals and the educational level and faith affiliation of the directors and chaplains. However, these findings are significant because they show that addressing the cultural, racial, and ethnic disparities in chaplaincy services could have a serious impact on health beliefs and behaviors. There was a recent shift in pastoral care from a religious-based service to one of universal appeal, and the "one-size-fits-all" approach has clear limitations when used with Muslim patients. In this study, non-Muslim chaplains recognized a need for an imam when Muslim patients require specific rituals.

Introduction

AS MORE HOSPITALS ACKNOWLEDGE the importance of spiritual care, there is an increasing demand for chaplains to meet patients' needs. However, in the United States, chaplaincy is typically practiced within the context of Judeo-Christian tradition. Despite having distinct spiritual and health care needs as they relate to daily rituals and worship, medical ethics, and end-of-life treatment choices, American Muslim patients are often underrepresented in the realm of spiritual care services. Very few empirical studies have addressed the religious diversity among hospital chaplains and their roles in serving a multicultural population.

Although there is no definitive link between religious guidance and improved health, some studies suggest that chaplaincy plays an important role in helping patients cope with physical illness.²⁻³ In its accreditation of hospitals in the U.S., the Joint Commission requires hospitals to respect "the patient's cultural and personal values, beliefs, and preferences" and to accommodate "the patient's right to religious and other spiritual services".⁴ In an increasingly multicultural society like the U.S., the expectation is that the diverse needs of all faith communities will be met. However, in the U.S., health care chaplaincy services have not evolved as quickly as the population they serve, and the spiritual needs of minority religious groups often are not adequately addressed.⁵⁻⁷

Many professionals and patients perceive the chaplain's role as dealing solely with end-of-life issues.⁸ While prayer, emotional support, and issues relating to grief and death were perceived to be very important, conducting religious services, performing community outreach, consultation, and advocacy were viewed as moderately to very important in a chaplain's role.¹ However, the degree of importance accorded to these roles varied considerably by discipline and hospital type¹, hospital size, location, and church affiliation.⁹

As more hospitals and health care institutions acknowledge the importance of spiritual care, there is an increasing need for chaplains and clergy members who can meet patients' spiritual needs.¹⁰ While chaplains are traditionally not fully established and integrated members of a hospital staff¹¹ (Norwood, 2006), they play an important role in supporting and strengthening patients' religious and spiritual beliefs and practices, particularly in the recovery process.¹²⁻¹⁴

According to Amos (2007) "the word 'chaplain' has a Christian connotation. It means an authorized person who gives pastoral and spiritual care outside the main institutional structure of the Church".¹⁵ Recently, more efforts have been made to extend the traditional services of 'chaplaincy' to embrace the needs of multifaith societies. In 1948, for example, the US Department of Health advised hospital authorities to provide spiritual care by appointing paid chaplains from different traditions and faith groups other than Christianity¹⁶ (Porter, 1999). In addition, in the United Kingdom, the context of chaplaincy has shifted from being applied in a Christian ecumenical fashion, to providing more inclusive religious and spiritual services.¹⁵ Despite these promising statements, as of yet, little attention has been paid to the roles Muslims chaplains can and do play in health care settings.

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Muslims in the U.S. and in New York City

ISLAM IS ONE OF THE FASTEST GROWING religions in the United States, and it was projected that by the year 2010, Muslims will have become the second largest religious group in America after Christians¹⁷. In 2000, 2.9 million of 8 million New York City residents reported being foreign-born. These immigrants come from diverse ethnic backgrounds, in numbers unmatched in any other U.S. city.¹⁸ In New York City, there are about 600,000 Muslims¹⁹, and they are almost equally represented by three major racial or ethnic groups: African American, Middle Eastern (including Arabs and Persians), and South Asian (mostly Pakistanis and Indians).²⁰ These diverse groups signify a wide spectrum of adherence, religious practice, rituals, and traditions. However, their core spiritual belief is remarkably uniform compared to many other religions.²⁰ For example, Muslims who practice Islam adhere to all or to most of the five pillars of Islam, including utterance of the *shahada* (the Islamic statement of faith), daily prayers, fasting during the holy month of Ramadan, giving *zakat* (charity), and pilgrimage to Mecca.²¹

Islam and Health

MANY MUSLIMS AROUND THE WORLD consider their beliefs to be the most important aspect of their spiritual essence,²² especially as they relate to daily practices, health care needs, medical ethics, and end-of-life treatment choices. The chaplain thus serves as a cultural broker, guiding patients toward health care decisions that are congruent with their beliefs and spiritual needs. In today's highly advanced health care system, complicated ethical questions regarding patient care arise frequently. Many Muslim patients draw upon Islamic legal tradition and religious scripture for guidance when making difficult decisions, including whether to continue aggressive treatment, participate in family planning, or receive or donate organs.²³⁻²⁴ Professional chaplains who are knowledgeable about Muslim traditions may serve as spiritual care liaisons between patients and their families, and staff members who need to understand the specific needs and values of Muslim patients.^{7,6}

To understand Islamic perspectives of spiritual care one must understand the religion, cultural beliefs, values, and world views of Islam. The religious values and beliefs of Muslims are markedly different from those traditionally found in the western hemisphere.²⁵ Religious Muslims pray five times a day facing Mecca, and only after a ritual washing with which a sick patient may require assistance.²⁶ Some challenges to the Muslim patient and hospital staff can include meeting dietary restrictions or questions about the safety of fasting during Ramadan.

Islam upholds the sanctity of life and views it as solely from the provision of God.²⁷ When death is imminent, the Muslim lifts a finger towards heaven and recites the *shahada*, or the declaration of faith in the oneness of God.²⁸ If the patient is too weak to do this, assistance from a family member or another Muslim may be required. Upon death, the mouth and the eyes are closed, the head is turned towards Mecca, and the body is ritually washed by Muslims of the same sex. Organ transplants are permissible

in certain Muslim cultures and under specific circumstances.³¹ It is crucial for western-trained chaplains to be educated in the practice of Islam as it relates to illness and death for the comfort and relief of Muslim patients receiving health care.⁷ Patients who share a similar ethnic and cultural background with their chaplain are able to establish a trust-based relationship, considering the chaplain as an advocate. Conversely, ethnic and cultural differences between chaplain and patient can impede the relationship and its effectiveness.⁶ The provision of culturally appropriate spiritual counseling to meet the needs of Muslim patients is integral to their care, enabling them to feel more comfortable using resources that cater to and satisfy their specific spiritual needs.

TABLE 1: Participants' Characteristics: Demographic Background

VARIABLE	DIRECTORS		CHAPLAINS	
	N	(%)	N	(%)
Average Age (in Years)	56.5		56.7	
Department:				
Nursing	3	(5.4%)	–	
Pastoral Care	51	(91.1%)	–	
Patient/Social Services	2	(3.6%)	–	
Department Total	56	(100%)		
Gender:				
Male	28	(56%)	23	(69.7%)
Female	22	(44%)	10	(30.3%)
Gender Total	50	(100%)	33	(100%)
Education:				
BA	6	(10.7%)	5	(5.1%)
MA	39	(69.6%)	20	(60.6%)
Ph.D./Doctorate	11	(19.6%)	3	(9.2%)
Education Total	56	(100%)	33	(100%)
Borough:				
Manhattan	20	(35.7%)	11	(33.3%)
Brooklyn	15	(26.8%)	7	(21.2%)
Bronx	5	(8.9%)	6	(18.1%)
Queens	12	(21.4%)	5	(15.2%)
Staten Island	4	(7.1%)	4	(12.1%)
Borough Total	56	(100%)	33	(100%)
Type of Setting:				
General Hospital	37	(66.1%)	23	(69.7%)
Long-Term Care	2	(3.6%)	6	(18.2%)
Psychiatric Hospital	3	(5.4%)	4	(12.1%)
All the above/Hospice	14	(24.9%)	–	
Type of Setting Total	56	(100%)	33	(100%)

Methodology

THIS STUDY WAS DESIGNED to examine several issues related to chaplaincy services: the availability of such treatment to Muslim patients, the approaches that Muslim and non-Muslim chaplains take to care for Muslim patients, and the role of Muslim chaplains in addressing Muslims' spiritual and religious care in NYC hospitals and health care settings.

The major research questions are as follows:

- a. What types of culturally appropriate spiritual resources do Muslims currently have and what is needed?
- b. How are the needs of Muslim patients in NYC hospitals and health care settings perceived, in comparison to the needs of non-Muslim patients?
- c. What approaches do Muslim and non-Muslim chaplains use in providing spiritual and religious care for Muslim patients?
- d. What are perceived major barriers Muslim patients face in utilizing pastoral services?
- e. How do directors and chaplains of NYC hospital pastoral care departments perceive the role of Muslim chaplains when serving Muslim patients?

These questions were investigated by using both quantitative and qualitative research methods. To address the large scope of the research topics, we issued a number of questionnaires and held numerous face-to-face interviews. First, a list of 45 directors at New York City hospitals was provided by the HealthCare Chaplaincy organization and another list of 40 directors was identified directly through hospital websites. Second, a survey questionnaire and letter were mailed to all 85 potential directors inviting them to take part in the study. Six surveys were returned for incorrect addresses, and 56 surveys were completed and returned, for a response rate of 71%.

The survey questionnaire consisted of two major sections. The first section was designed to obtain socio-demographic information about general characteristics of the directors and the hospital/health care setting, including location, size, average number of patients in general and Muslim patients in particular. The second section used a 19-item scale developed by Flannelly et al. (2006) on the importance of different chaplain roles and activities¹; the scale items were measured on a 6 point-Likert scale (0 = not at all important to 5 = extremely important). The scale items were divided into seven categories including:

1. grief and end-of-life care (items 1, 2, & 3);
2. emotional support to patients and their family members (items 16, 17, & 18);
3. community liaison and outreach (items 7, 8, & 9);
4. directives and donations of organs (items 10 & 11);
5. religious services and worship (items 4 & 5);
6. consultation and advocacy (items 12, 13, 14, 15, & 19); and
7. prayer (item 6).

“...WE INVESTIGATED
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The Cronbach alphas for these six measures in ranged from $CZ = .73$ to $= .91$.¹ In this study the scale was slightly modified to reflect the perception of hospital Muslim chaplains. For example, instead of asking the question in general terms *“In your opinion, how important is it to have chaplains be part of the palliative care team ...”* we added the word Muslim and the question reads *“In your opinion, how important is it to have Muslim chaplains be part of the palliative care team...”*. Our Cronbach alpha for the same categories ranged from 84 to 97.

For the face-to-face interviews, 40 hospitals were randomly selected from New York City’s five boroughs. The investigator was granted 33 interviews in total. All interviews were conducted in English, in a hospital setting. Informed consent and study procedures were reviewed and approved by the Institutional Review Board of Adelphi University. All face-to-face interviews generally followed the interview guide using open-ended questions designed to investigate whether they have ever cared for Muslim patients, and if they had, to gain insight into their experiences. We also examined whether or not they had participated in any cultural competency training in managing Muslim patients. Finally, we investigated the major barriers facing Muslim patients in receiving medical services, and what measures should be taken to better address their needs.

Data Analysis

UNIVARIATE AND BIVARIATE statistical analyses were used to analyze the quantitative data and to determine the correlations among variables. Because of the severe skewness coefficients and the outlier cases found in part of the data, the median was reported in addition to the mean. Descriptive univariate analysis was used to analyze the quantitative data.

All interviews were conducted in English at the hospital sites. Transcripts of all interviews were reviewed, coded, and categorized through continuous comparison. For the qualitative/interview section, a grounded thematic approach was used to analyze the transcripts using the computer-assisted qualitative data analysis software package ATLAS.ti.

Results

SAMPLE CHARACTERISTICS

Out of the 56 returned surveys, the majority of respondents (n = 51, 91.1%) reported having a pastoral care department. Of the total sample, three hospitals (5.4%) handled pastoral care needs through the nursing department, and two hospitals (3.6%) through the patient/social services department. Nearly half of the participants had the title “pastoral care director.” Most directors (36%, n = 20) and chaplains (34%, n = 11) in this study worked in Manhattan and Brooklyn hospitals (27%, n = 15; 21%, n = 7, respectively). The majority of directors (56%, n = 28) and chaplains (70%, n = 23) were male, and 66% of the participants held master’s degrees or higher, and share the same mean age of approximately 57 years. While none of the directors were Muslim, the chaplains represented a broader range of religious affiliation, including Christian (49%, n = 16), Jewish (21%, n = 7), and Muslim chaplains (30%, n = 10). About two-thirds of the directors (66%, n = 37) and the chaplains (70%, n = 23) served in general hospitals ([see Table 1 on page 4](#)).

The majority of hospitals ranged in size from medium to large (201 to 600+beds) facilities. About half (48%, n = 11) of the non-Muslim chaplains (four female and seven male) were board-certified. Of the 10 Muslim participants, one was a board-certified chaplain. The median number of licensed hospital beds reported by 52 directors was 382.5 (Mean = 477, SD = 259.7), while the median daily patient census for the 43 responding directors was 200 (Mean = 241, SD = 167.4). The median number of patients referred to chaplains by faith daily indicated that the majority were Jewish (Median = 32.8, Mean = 61, SD = 78.8), followed by Christian (Median = 20, Mean = 50, SD = 66.1), then Muslim patients (Median = 11.52, Mean = 17, SD = 19.7) and others (Median = 12, Mean = 16, SD = 19.3) ([see Table 2 on page 8](#)).

Ninety-one percent (n = 54) of 54 responding directors employed paid chaplains; 75% (n = 35) hired up to five chaplains-in-training (chaplains who already obtained some training in chaplaincy services but were not board-certified), 62% (n = 26) of 42 responding directors hired up to five board-certified chaplains; 89% (n = 46) of 53 responding directors contacted local clergy (including priests, rabbis, and imams); and 61% (n = 34) of 56 responding directors used staff members (physicians and nurses) for chaplaincy services. The majority of 47 responding directors (70%, n = 33) reported that they hired up to five full-time paid chaplains, and 47% (n = 22) hired up to 10 unpaid volunteer chaplains ([see Table 3 on page 9](#)).

1. A Board Certified Chaplain (BCC) is defined as: “a person who has demonstrated professional excellence as a chaplain, meeting all eligibility requirements including a Bachelor’s Degree, a 72 semester credit graduate theological degree from an accredited school, four units of clinical pastoral education (CPE) ordination or commissioning to function in a ministry of pastoral care, and ecclesiastical endorsement by a recognized faith group, is recommended by a Certification Committee, approved by the commission on Certification, and ratified by the Board of Chaplaincy Certification Inc. Board of Directors.” (Association of Professional Chaplains, retrieved from www.professionalchaplains.org).

The Needs of Muslim Patients as Perceived by NYC Hospital Pastoral Care Directors and Chaplains

THE RESULTS OF THE STUDY revealed definitive trends in Muslim patient care and the impact of chaplains in medical settings. About half of the 33 Muslim and non-Muslim chaplains interviewed reported that Muslim patients asked for Islam-specific items or advice; however, most of the non-Muslim chaplains suggested that the Muslim patient population is low and that they do not object to the lack of Muslim chaplains or imams or request them.

“ALTHOUGH MUSLIM PATIENTS PREFER A MUSLIM CHAPLAIN, THE PATIENT POPULATION IS SOMETIMES TOO LOW TO JUSTIFY HIRING A MUSLIM CHAPLAIN.”

One specific idea arose twice in the face-to-face interviews: “*The Muslim patients do not have the same needs in a hospital as, say, Catholic patients (sacraments or last rites, anointing the sick) or Jewish patients (kosher food, Sabbath accommodations)—nothing that specifically requires seeing an imam.*” Two Christian chaplains agreed that most of the Muslims [in their hospitals] are secularized and do not require [an imam]. A Christian chaplain suggested that Muslim patients’ “*needs seem to be met by the family or community.*” Finally, a Jewish chaplain expressed about Muslim staff: “*There is usually no need [for an imam], since many Muslim doctors are very religious, and act as imams. When a person dies, Muslims do not need an imam, the family takes care of all the needs.*” Despite the fact that about half of the 33 chaplains interviewed reported that Muslim patients sought some kind of service specific to Islam, it is clear that, among non-Muslim chaplains, there exists a lack of awareness and understanding of their religious needs.

TABLE 2: Hospital Size: Licensed Beds and Average Patients Census

AVERAGE PATIENT CENSUS	TOTAL N	MEAN (S.D.)	RANGE
Overall licensed beds	52	446.81 (259.73)	100 – 1200
Avg. patient census in general	43	241.1 (167.44)	30 – 693
Avg. patient census by Christian faith	43	50.12 (66.13)	00 – 285.3
Avg. patient census by Jewish faith	42	61.44 (78.82)	00 – 402.9
Avg. patient census by Muslims faith	43	16.86 (19.65)	00 – 90
Avg. patient census by others	42	16.13 (14.28)	00 – 60
Muslim patients served per year**	34	129.53 (338.21)	00 – 1800

** 22 participants out of the 56 participants (39%) reported that either they don’t have statistics about Muslim patients or they are unaware/unsure.

Interfaith Chaplaincy

WHEN ASKED HOW they approach Muslim patients, most chaplains explained that they tend to them in the same manner as all other patients. Some limit their tasks to “providing religious services” or “offering scripture or prayer,” while others “offer encouragement to the patient to practice faith,” or to ask more generally, “if they need anything from their faith”. Some spoke of assessing emotional and spiritual needs, “meeting [patients] where they are,” “making them feel secure,” and “welcomed and embraced spiritually.” Others attempt to build trust by “listening” and “being available,” so that patients can “talk about their problems.” In a description of a typical visit, two chaplains report they introduce themselves, engage in conversation, ask the patient if he or she has any emotional or spiritual needs with which they may be able to help, and then offer a prayer. According to these chaplains, some Muslim patients are open to having a prayer read by a non-Muslim, while others will refuse. The chaplains are trained to make a visit by offering support in a way that is sensitive to the patient’s spiritual and emotional needs. A chaplain shares the way he identifies the spiritual object that is helping the patient and how they are able to cope with the suffering: “You have to ask if you can visit. It’s a process and takes years of training. You do not just ask for prayer right away. My CPE (Clinical Pastoral Education) training supervisor would say that if you leap to prayer too quickly, you haven’t gone far enough. This is a non-CPE approach.

You’re trying to help people with struggles they’re going through. God comes out in the hospital. You’re suffering in the hospital. Everyone wants to talk about pain. Sometimes Muslims will talk to me about their illness...how [they’re] feeling, what’s going on.”

A Muslim chaplain likewise explains that he learned this “pastoral care” approach in CPE: “CPE educates you regardless of faith tradition. When you are an imam, you know how to minister to Muslim patients only. When you do [the] CPE course, you learn how to minister without being of the same faith as the patient. The motto of CPE is ‘without having the same faith, [you] can minister to the patient [for the] spiritual healing of that person.’ CPE educates the chaplain to minister to the patient in his or her faith. Spiritually, many patients are distressed. You should not abandon a patient [but rather] give encouragement to the patient to practice faith. Some people do not practice any faith, but believe in a spiritual power.”

Though this interfaith model of pastoral care for all patients across religious boundaries is the dominant form for most chaplains interviewed, several identified some limitations. For instance, one Jewish chaplain says, “when specific requests are made for a religious ritual or culture-specific prayer ...chaplains are always referring patients to [other chaplains] when specific religious needs cannot be met. When in need of an imam in a life-or-death situation, I often call for an imam at the large mosque almost eight blocks away.”

TABLE 3: Mean Number of Employed Professional and Volunteer Chaplains By Faith

EMPLOYED PROFESSIONALS	TOTAL N	MEAN	S.D.	RANGE
Of Christian faith?	52	2.95	3.99	0 – 21.00
Of Jewish faith?	51	.88	.81	00 – 4.00
Of Muslims faith?	49	.30	.478	00 – 1.50
Of other faiths?	49	.22	.51	00 – 2.00
UNPAID VOLUNTEER CHAPLAINS				
Of Christian faith?	44	9.30	13.61	00 – 66.00
Of Jewish faith?	43	2.81	5.58	00 – 30.00
Of Muslims faith?	43	.67	1.11	00 – 4.00
Of other faiths?	44	1.25	2.24	00 – 9.00



“ALTHOUGH CHAPLAINS
RECEIVE CULTURAL
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MATERIAL ABOUT ISLAM
IS OFTEN NOT INCLUDED
IN THE TRAINING.”

Barriers Facing Muslim Patients and Non-Muslim Chaplains

ABOUT ONE-THIRD of responding directors reported that Muslim patients were served by *imams*, while others reported that they did not know or were unsure how the Muslim patients were served, or the data was otherwise unavailable. About 86% (n = 48) of 56 responding directors articulated that the primary barriers to serving Muslim patients could be classified into six major areas, including language barriers between patients and chaplains, lack of cultural understanding by the hospital staff regarding the religious rituals and practices of Muslim patients, perceived fear of prejudices by Muslim patients, the practice of chaplaincy through a Christian framework, a lack of trained Muslim chaplains and access to community resources that support Muslim patients, and a lack of awareness among Muslim patients of the existing chaplaincy services. Other barriers cited include vulnerability, a lack of identification between chaplain and patient, and Muslim patients’ fear of discrimination after 9/11 as major barriers to care. However, the board-certified chaplains and all Muslim chaplains interviewed reported that they are trained or know how to overcome each of these barriers, and how to build relationships and trust over time.

In addition, at least three non-Muslim chaplains admit to experiencing barriers from their perspective. Some non-Muslim chaplains find that volunteer *imams* are helpful in addressing Muslim patients’ needs, but tend to perceive them as barriers to caring for Muslim patients. To them, *imams* were not trained to conduct pastoral care and unwilling to go through the hospital process for approval.

The majority of the directors and chaplains indicated that chaplains have taken at least one required cultural competency training session, but that the material was not specific to Islam. Others used more informal approaches, such as taking the initiative themselves to learn, relying on Internet resources, or consulting regularly with Muslim relatives or local *imams* to learn more about Islam and Muslim patients’ needs.

The non-Muslim chaplain faces specific barriers in serving Muslim patients, such as sensitivities around gender and politics. Twenty-nine chaplains mentioned the need to respect standards of modesty and male–female interaction when interacting with Muslim patients. Five non-Muslim chaplains said that they were somewhat hesitant and very careful when visiting a Muslim patient of the opposite sex, or their visits could be rejected. One Christian chaplain admitted that seeing a [Muslim] woman in a full face veil “gives you a funny feeling” and that she finds it “repressive and oppressive.” A Jewish chaplain commented that he always avoided discussing any political subjects with Muslim staff and patients, though he is “on friendly terms” with them.

What Should Be Done to Address the Needs of Muslim Patients?

CONSISTENT WITH THE RANGE of ideas about what Muslim patients need, chaplains articulated a range of strategies to address these needs. One group of four chaplains (Protestant, Catholic, and Jewish (board-certified and non-board-certified)) agreed that Muslims ask for very little or something as basic as prayer beads or a Qur'an; two of these chaplains indicated that they had access to prayer beads and Qur'ans. A Catholic, non-certified chaplain reported that Muslims do not need any ministering, the patients saying "we're okay on our own." A board-certified Jewish chaplain suggested that most Muslim patients were foreign-born, did not request anything, and likely wanted to break away from their traditions.

A second group of six chaplains, diverse by religious affiliation and certification, were ambivalent toward the needs of Muslims and suggested that an imam would be better able to assess their needs. A Jewish chaplain remarked, *"Muslims, like Catholics, do not usually want to talk to a rabbi."* A Catholic chaplain wondered how Muslims viewed pastoral care, and another chaplain wondered how he would get a Qur'an if someone asked, and whether there were special Muslim prayers for the sick. The other two chaplains admitted that they did not know what Muslim patients needed. One board-certified Jewish chaplain said: *"Muslims are 'normal patients' [who] have problems just like everyone else; they should not be singled out with questions about their unique needs."*

A third group of six non-Muslim chaplains suggested that Muslim patients should be treated as individuals with specific needs. The two Jewish chaplains recommended assessing a Muslim patients' need for prayer, support, pastoral visits, or consultations with an imam on medical decisions, and making any reasonable accommodations for them. Four Christian chaplains in this group report talking to Muslims about their faith and what helps them. For instance, one female chaplain said: *"My job is to rally for them while they're here, and in treatment. What is happening during is what I'm interested in. It's a process of assessment, where is one spiritually and theologically? What will help them, so their beliefs and values will help them and not work against them? Clergy often come in assuming that the patient knows doctrine—not true! Most people have a shallow knowledge of their faith."*

The ten Muslim chaplains who assist Muslim patients believed that they usually attend to the needs of this demographic that are often unaddressed in hospitals. Two Muslim chaplains suggested that they bring to Muslim patients a theological perspective on illness, framing the experience in terms of a personal struggle or jihad: *"A personal jihad is to persevere, to struggle, to push on through a crisis. It's a struggle with the soul to push through something. Illness is a part of personal jihad—to push through."* They speak of illness as a test or an opportunity for purification and forgiveness and contrast this with non-Muslim perspectives on illness which might include punishment or existential crises about God's justice. All of the Muslim chaplains report that they pray and recite the Qur'an with patients, and two say they offered literature available in a patient's language.

Two other Muslim chaplains pointed out that they do not have adequate funds or supplies relative to other chaplains and provide their own resources if patients request reading materials. As one chaplain says: *“Other chaplains get a lot of material—a supply of Bibles, and so forth, I do not.”* All the Muslim chaplains report that Muslim patients are happy to see them, find them a familiar presence, and want to talk. Only Muslim chaplains spoke of certain roles in regard to Muslim patients. These included the rituals of reciting specific prayers at birth, participating in male circumcisions, and reciting verses of the Qur’an while someone is dying. Muslim chaplains also articulate their role as providing both spiritual guidance and education about faith and practice to Muslim patients, and some also serve as Friday preachers. Muslim staff members and patients’ families are the primary beneficiaries of the latter service, because most of the patients themselves cannot physically get to the chapel.

Role of Muslim Chaplains

OVERALL, MUSLIM AND NON-MUSLIM chaplains agree that having Muslim chaplains on the hospital team is very important. As a non-Muslim chaplain stated *"I would love to have an imam who could come, but nobody wants to volunteer their services."* Another chaplain perceived the importance of the Muslim chaplains as providing a more culturally sensitive role. *"For example, halal meat, services during holidays, sensitivity for Muslim issues, and fasting during Ramadan. It has to come from outside, not inside."* One Muslim chaplain suggests that Muslims chaplains need to take responsibility for increasing the supply such as Qur'an, prayer beads, and halal food.

A non-Muslim chaplain assigned what would seem like an unusual role for Muslim chaplains to take on themselves, which was overcoming negative stereotypes about Muslims among staff: *"It would be so great to have more Muslim chaplains to counteract how people feel about Muslims post-9/11. There's fear out there about Muslims and chaplaincy can change this and serve to counterbalance this perception. If you had an imam/Muslim chaplain sitting in the CPE group, people would get to know him. If he made rounds, people would see that Muslims are not so bad."*

One Muslim chaplain perceived the role of a Muslim chaplain as an educator, and reported being asked to explain to hospital staff about fasting and taking medications, and about head coverings and beards. While another perceived the role of Muslim chaplain as a counselor, "talking with patients about the meaning of their illness," a non-Muslim chaplain viewed the role as that of an educator on organ donation. Another suggests that the role of Muslim chaplains is cultural brokers who can overcome some barriers to interaction with Muslim patients. Although some board-certified Muslim and non-Muslim chaplains report that they are trained to overcome any such barriers between Muslim patients and non-Muslim chaplains, a Muslim chaplain stated that these barriers are easier to overcome for imams or a Muslim chaplain than for non-Muslim chaplains: *"Once a chaplain was making the rounds and visited a female Muslim patient. He felt that she was not being receptive to him. He informed her that there was an imam here, and she wanted to see him."*

At least three non-Muslim chaplains perceived the Muslim role as helpful on providing prayer services, especially in dealing with Muslim patients and because of their "lack of knowledge, lack of specific training in Muslim culture and prayer, no comfort level with prayers," or due to the "certain restrictions" in Islam. Muslim and non-Muslim chaplains agreed that one of the most important role and activity of the Muslim chaplains is providing prayer services. All ten Muslim chaplains report that they have very distinguished roles in praying and reciting the Qur'an with patients, and two say they offer literature they can find in a patient's language. One Muslim chaplain sees the role of Muslim chaplains as an advisor. For example, he advises Muslim patients on alternative forms of performing ritual worship when disabled by illness or constrained by medical devices.



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Discussion

IN THE UNITED STATES, chaplaincy services are designed and practiced according to a paradigm of pastoral care or “spiritual care” for all, regardless of religious affiliation. Chaplains are often trained, paid, and credentialed by specific denominational institutions, but nevertheless frequently serve outside those particular boundaries of religious affiliation. Chaplains of other faiths often argue that Muslim chaplains are not necessary because Muslims have the same needs as everyone else. On the other hand, the lack of awareness of Muslim patients, and the lack of available services for them, could also be explained by the fact that non-Muslim chaplains do not have extensive knowledge of Islam and Muslims. This argument was recognized in chaplains’ comments that Muslims do not have the same rituals as Jews, the same sacraments or ordinances as Catholics and Protestants, and their admission that they are “not well-versed” in the particulars of Muslim practices. In contrast, Muslim chaplains mention specific birth and death rituals, prayers, and recitations from the Qur’an, and words of comfort drawn from Islamic theology. It seems necessary to demonstrate the need for the provision of Muslim chaplaincy services in order to justify them. These specific needs include theological perspectives and counseling about illnesses, ethical and legal advice regarding ritual obligations, as well as medical decisions, ritual prayer, and Qur’anic recitation.

Qualitative analysis reveals the belief that the provision of religion-specific spiritual care should be based on demand, as measured by proportional representation in the patient population. But the results of the quantitative study contradict this rationale. The ratio of full-time Christian chaplains to the median daily census of Christian patients was found to be 2:20, for Jewish patient was 1:33, while the ratio of full-time for Muslim and other patients were 0:11.5 and 0:12, respectively. This finding suggests that hospitals may be providing unequal chaplaincy services, favoring Christian patients compared to patients of different faiths.

Regarding the provision of chaplaincy services for Muslim patients, some have argued that non-Muslim, trained chaplains must be educated in the practice of Islam as it specifically relates to illness and death. Others have argued that chaplains who share a similar ethnic or cultural background with their patients are more likely to reach their patients. Muslim chaplains are limited, however; there are only two board-certified Muslim chaplains in over 70 hospitals operating in the five boroughs of New York City, and, according to D. Martino, eight board-certified Muslim chaplains in the entire United States (personal communication, 13 July 2009). Results from this study indicate that there are only two imams who are employed full-time and paid by the state of New York, and 23 non-Muslim chaplains employed through hospitals.

Although some directors and most non-Muslim chaplains believe they know how to address Muslim patients’ needs, they perceive the role of Muslim chaplains as important, especially among directors and chaplains who serve in Manhattan hospitals than those who serve in other areas, and also in hospitals where more

Jewish chaplains are employed. This indicates that hospitals located in urban areas are more likely to have a more multicultural approach to patients in addressing the specific and distinct needs of their patients.

They also seem to be more appreciative of cultural differences, and more eager to meet the distinct needs of their diverse patients by either reaching out to the Muslim community, local *imams*, or to Muslim hospital staff members. In other words, hospitals that employ a diverse range of chaplains from other faiths are more likely to assign a greater importance to Muslim chaplains' roles and activities than hospitals that only offer chaplaincy accommodation to patients from a dominant faith. On the other hand, smaller hospitals and those located in rural areas were less likely to have Muslim chaplains on their staff. This most likely reflects differences in the diversity of the population the hospital serves, religious leadership, and financial resources in these areas. Smaller and/or rural hospitals might not have resources available to hire chaplains, or there may be less need because local religious leaders are more readily available.⁹

In addition, these studies shed light on the many roles Muslim chaplains serve. It is important to note that the major focus given by directors and chaplains to the Muslim chaplain's role within the hospitals was extended to include non-traditional functions such as providing directives and consultations to patients and their family members, as well as to other chaplains, physicians, and hospital staff members, depending on the patient's needs and concerns.

At the policy level, special consideration must be given to the differences between Muslim and non-Muslim patients' needs. To increase the use of spiritual care services among Muslim patients, chaplains and hospitals must identify the important roles Muslim chaplains can offer and the special approaches they take in addressing Muslim patient's needs. Such policies may include developing board-certified chaplaincy training for Muslim chaplains, recruiting community-based imams, and providing interfaith CPE training. In addition, all healthcare professionals need to recognize varying perceptions of health shared

by people from different religious, sociocultural, and ethnic backgrounds in order to deliver culturally sensitive healthcare.

As the United States becomes a more racially and ethnically diverse nation, health care systems and providers need to respond to patients' varied perspectives, values, and behaviors about health and well-being. Failure to understand and manage social and cultural differences may have significant health consequences for minority groups. Health care experts in government, managed care, academia, and community health care make a clear connection between cultural competence, quality improvement, and the elimination of racial and ethnic disparities.

The success of meeting the needs of Muslim patients and all patients has strong public health policy implications. The findings could help inform chaplaincy providers and health service planners toward improving the appropriateness, relevancy, and effectiveness of services for Muslim patients. By providing appropriate services to patients, they are more likely to experience positive change, and more likely to overcome physical and mental challenges. The positive outcome will likely decrease the number of days of hospitalization and minimize the economic burden that chaplaincy services place on hospitals and health care settings.

Recommendations

Based on the study findings, we recommend the followings:

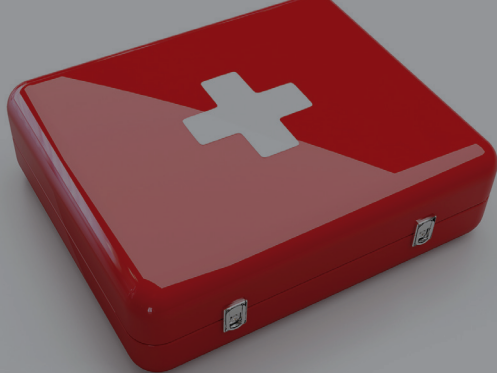
- Special consideration must be given to the differences and similarities between Muslim and non-Muslim patients' needs. To increase the use of spiritual care services among Muslim patients, chaplains and hospitals must identify barriers and develop approaches to remove them. One means is through coherent and comprehensive chaplaincy training for Islamic chaplains, community-based imams, and interfaith CPE residents in training. For example, bioethics competency training of Islamic chaplains can give them the skills to comfort both patients and physicians faced with ethical or spiritual dilemmas.
- The training of Muslim chaplains, to meet the needs of Muslim patients, will need to account for the ways that Muslim religious leadership differs from Christian and Jewish models as well as the internal diversity of Muslim-American communities. Furthermore, developing Islamic chaplaincy core competencies should include a basic knowledge of bioethics, as many Islamic chaplains serve as cultural brokers in the hospital setting.
- The current challenge within the NYC hospital setting is that there are two board-certified Muslim chaplains in NYC, and only one is active. Other Muslim chaplains serve as local *imams* with very minimal training in chaplaincy services. Therefore, Muslim chaplains generally lack the knowledge or qualifications required by chaplaincy departments. Although suggesting that the professional training and certification of Muslim chaplains is important, we also recognize that knowledgeable activists may exercise as much or more leadership and authority in the broader Muslim community as traditionally educated *imams* and jurists. A number of institutions are currently evolving to address the increased need for indigenously trained Muslim religious leaders in the United States. New York City and other major urban centers with large Muslim communities should follow this lead and consider recruiting Islamic chaplains from established pastoral care programs and seminaries.

- The general lack of data suggests that an appropriate needs assessment for Muslim patients has never been done. A good appraisal of the Muslim patients' spiritual needs should be designed to gather enough information on all patients spiritual needs, and not limit these questions to certain faiths. Further studies are required to address this gap in our knowledge of Muslim patient utilization of and demand for hospital services. Federal and state agencies should provide independent funding for research in the field of Islamic chaplaincy and its role in delivering services to Muslim patient populations.
- The Muslim chaplain's perspective addresses several concerns such as not being a full-time employee, not being fully paid by the hospitals, and not being certified or well-trained in chaplaincy services despite a wealth of knowledge about hospital policies and requirements. At the local level, reaching out to Muslim patients by hiring professional Muslim chaplains may help narrow the gap between hospital health care providers and community-based Muslim spiritual care providers.



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