March 2011 Article of the Month

This month's article selection is by Chaplain John Ehman,
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Abu-Ras, W. and Laird, L. "**How Muslim and non-Muslim chaplains serve Muslim patients? Does the interfaith chaplaincy model have room for Muslims' experiences?**" *Journal of Religion and Health* 50, no. 1 (March 2011): 46-61.

SUMMARY and COMMENT: Wahiba Abu-Ras, PhD, is Assistant Professor of Social Work at Adelphi University and President of Muslim Mental Health; and Lance Laird, ThD, is Assistant Professor of Family Medicine at Boston University's School of Medicine, where he is Assistant Director of the Boston Healing Landscape Project, a "program for the study of cultural, therapeutic, and religious pluralism." Their research explores "the approaches of Muslim and non-Muslim chaplains to providing spiritual and religious care for Muslim patients and how they portray the needs of Muslim patients in [New York City] hospitals and health care settings in comparison with the needs of non-Muslim patients," as well as "...the types of culturally appropriate spiritual resources Muslims currently have, and what is needed" [p. 49].

From a sample of 40 hospitals in New York City's five boroughs, "in-depth, semi-structured face-to-face interviews" were arranged with 33 chaplains: 10 Muslim, 7 Jewish, and 16 Christian. Participants were asked " (a) what experience [they] have in caring for Muslim patients, (b) their assessments of Muslim patients' needs, (c) their approaches to pastoral care with Muslim patients, (d) what spiritual resources Muslims currently have, and (e) what measures should be taken to address Muslim patients' needs" [pp. 49-50].

Among the results:

- "Seventeen of the 33 chaplains reported that Muslim patients ask for one or more of the following: an imam, a Qur'an, literature about Islam, a prayer mat, someone to pray for them, instructions on how to say their prayers, special meal schedules for Ramadan, ablution space, and halal food.... On the other hand, fourteen participants, including one Muslim chaplain, reported that to their knowledge, Muslim patients have never asked for one or more of the following: an imam, prayer, Qur'an, halal food, prayer mat, gender-matched care, or use of the chapel." [p. 50]
- "When the 23 non-Muslim chaplains were asked how they perceived Muslim patients' need for chaplaincy services, most suggested that the Muslim patient population is low and that the existing Muslim patients do not request an imam or a substitute in their absence." [p. 51]
- "When asked how they approach Muslim patients, most chaplains explained that they approach Muslim patients in the same manner they approach all other patients." [p. 51] (This is illustrated with reference to Clinical Pastoral Education training.)
- Non-Muslim chaplains spoke of barriers in working with Muslim patients, including gender and political issues, and 29 of the participants "mentioned the need to respect standards of modesty and male-female

interaction." [p. 52]
- While non-Muslims tended to indicate that Muslim patients had relatively little need and often indicated no desire to speak with the (non-Muslim) chaplain, Muslim chaplains spoke of various needs. "Only Muslim chaplains spoke of certain chaplaincy roles in regard to Muslim patients, ...[including] the rituals of reciting specific prayers at birth, participating in male circumcisions, and reciting a surah (verse) 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." Nevertheless, "[b]oth Muslim and non-Muslim chaplains frequently state that their role in the hospital is to educate staff about Muslim patient concerns and needs and to ensure that the hospital respects them." [pp. 52-53]
- "The most common form of religious practice mentioned in the interviews was prayer." [p. 54]

In their discussion of the data, Abu-Ras and Laird consider "the 'one size fits all' approach to chaplaincy" -- namely, an interfaith/CPE model, especially as held by non-Muslim chaplains -- and how that "might present challenges for many Muslim patients" [p. 56]. They emphasize specific needs of Muslim patients that might thereby go unattended, including "theological perspectives and counseling about illnesses, ethical and legal advice regarding ritual obligations as well as medical decisions, ritual prayer and Qur'an recitation, and Friday sermons" [p. 57]. The authors report that non-Muslim chaplains in the study note a need to call upon local imams but have some difficulty accessing such resources, and they see in this fact a necessity for more Muslim chaplains. An argument for more Muslim chaplains is also supported by the data signifying "prejudice and discrimination against Muslim patients": "Several chaplains acknowledged their unawareness of Islam, doubts about their ability to discern Muslim needs, and their prejudices about 'seeing heavily veiled women'" [p. 57]. "We suggest that non-Muslim chaplains...need to take a measure of their gut reactions to Muslim patients in an Islamophobic social environment and how this environment influences their Muslim patients' responses to them" [p. 58].

The authors address the limitations of their study [p. 58] and seem fairly careful to distinguish between their discussion of the potentially broad implications of the data and any attempt to make sweeping generalizations. For this reader, that distinction did become blurred in some rhetoric: "One wonders whether Protestant, Catholic, or Jewish patients must ask for Bibles, prayers, worship services, or kosher food before the hospital begins making them available." In many hospitals, that situation may be more the case than the authors seem to assume, though the general thrust of the statement is well taken and instructive.

One of the more interesting comments in the article, to this reader, is an assertion that the "dimensions of proclamation, ritual, and theologically informed counseling and legal advice [which could address the needs of Muslim patients] might resonate with more traditional Protestant, Catholic, and Jewish practices, but not necessarily with contemporary interfaith chaplaincy practice" [p. 57]. This raises the complex and general question of the place of religion-specific needs within the interfaith model. Abu-Ras and Laird state further on: "Investigating how Muslims currently in chaplaincy training programs negotiate the integration of the interfaith CPE model with Islamic religious traditions might provide greater insight into the barriers and challenges to increasing the availability of professional Muslim hospital chaplains" [p. 57]. Perhaps studying the CPE experiences of Muslims in particular could also bring fresh perspectives on the educational issues behind the professionalization process of modern chaplaincy.

Suggestions for the Use of the Article for Discussion in CPE:

Thanks to a good introduction (for a lay audience) and clear writing, this article may easily be read not only by CPE students but by local clergy, health care workers, and even patients; and so it presents an opportunity to expand CPE discussion to include Muslim clergy and/or patients as well as Muslim and non-Muslim health care providers. For students with clinical experience, the open-ended questions used in the study's interviews would serve as an appropriate structure to begin the conversation: "(a) what experience [the students] have in caring for Muslim patients, (b) their assessments of Muslim patients' needs, (c) their approaches to pastoral care with

Muslim patients, (d) what spiritual resources Muslims currently have, and (e) what measures should be taken to address Muslim patients' needs" [pp. 49-50]. Students could be asked to respond to these items prior to reading the article (--essentially replicating the essence of the study informally) or afterward (in which case the question would be how the findings resonate with them). The sections on "Barriers for Non-Muslim Chaplains" and "What Should be Done to Meet the Needs of Muslim Patients?" may deserve special attention. Also, Abu-Ras and Laird hold that "it would be unfitting for Muslim patients to receive health care without incorporating spirituality" [p. 48]. Do students agree with this statement, and -- if so -- do they believe it should apply only to Muslim patients, to some non-Muslim patients as well, to all religious patients of any tradition, or to all patients generally? Finally, students should be encouraged to read, as a companion piece, Abu-Ras' "Chaplaincy services for Muslim patients in New York City hospitals..." [--see Related Items of Interest, §I, below].

Related Items of Interest:

I. The research presented in this month's featured article was part of a larger study of 56 hospitals in New York City. A November 1, 2010 report of that study, "**Chaplaincy services for Muslim patients in New York City hospitals: assessing needs, barriers, and the role of Muslim chaplains**," by Dr. Abu-Ras, is available freely from the Institute for Social Policy and Understanding. Dr. Abu-Ras also has an article forthcoming in *Topics in Integrative Health Care: An International Journal*: "**Chaplaincy and spiritual care services: the case for Muslim patients**" (scheduled for Summer 2011) --see the journal website at www.tihcij.com.

II. Abu-Ras and Laird provide a quite extensive bibliography, but there is unfortunately little other literature about chaplaincy to Muslim patients. One article that may be special interest:

> Hamza, D. R. "**On models of hospital chaplaincies: which one works best for the Muslim community?**" *Journal of Muslim Mental Health* 2, no. 1 (2007): 65-79. [(Abstract:) The Muslim community and professional chaplains associations are realizing the need for Muslim chaplains to get involved in the many institutions that require their services, such as universities, hospitals, prisons, and the military. Having observed different models by which hospital chaplaincies operate, the research presented in this article seeks to outline and examine three models of operating chaplaincy service: the chaplain-only model, the volunteer model, and the volunteer-chaplain model. While the models outlined here are restricted to hospital ministry, they might be beneficial, with varying degrees, to people engaged in other areas of chaplaincy services. This article investigates the model that might work best for the Muslim community, and ends with a summary of future steps for the proper implementation of this health care chaplaincy model.]

III. In a forthcoming article in the *Journal of Religion and Health* (available online ahead of print), Aasim I. Padela, et al., report interviews with 12 community leaders about the role imams play in community health. The authors also address the lack of imams serving as chaplains:

> Padela, A. I., Killawi, A., Heisler, M., Demonner, S. and • Michael D. Fetters, M.D. "**The role of imams in American Muslim health: perspectives of Muslim community leaders in southeast Michigan**." *Journal of Religion and Health* online ahead of print (as of November 2010). ["As imams take on a more visible role in the healthcare system, it is important to distinguish between the role of imams and Muslim chaplains. ...While they may serve, formally or informally, several roles that are similar to those of chaplains, i.e. spiritual support and religious advice for Muslim patients and families, imams may not necessarily have the skill-set to provide formal counseling, be involved in bioethics consults, and support patients outside of the Muslim faith. In our experience and that of other researchers, even in areas of large Muslim populations, few imams have formal

chaplaincy roles in the hospital.... There are several reasons this may occur. Imams may not have the time to devote to hospital activities given their mosque-based responsibilities. Imams may feel uncomfortable taking on a chaplaincy role due to their limited medical knowledge and may view chaplaincy as alien to their understanding of support of the sick as a communal, and not individual obligation in Islam.... From the healthcare system perspective, hospitals may not see a need for imams to be on staff since employed chaplains are expected to minister to patients from various religious backgrounds. Yet, pastoral care and chaplaincy training programs rarely include education on Islam, and it is uncertain if non-Muslim chaplains would feel morally comfortable counseling about a different religion.... Thus, hospital chaplains may not be able to fulfill the needs of Muslim patients. Additionally, hospitals may lack the financial resources or perceive Muslim patient volumes insufficient as to justify such hires. A further barrier may be that hospitals often require chaplaincy credentials, and as of yet, there are only a few Islamic chaplaincy programs in the United States.... Given that the title Imam carries different connotations...and imams have varied qualifications, healthcare systems and imams may face significant 'cultural gaps' to being hospital chaplains." (See the Discussion section --no page numbers appear in the ahead-of-print version.)]

IV. Our June 2003 Articles-of-the-Month page addresses issues with Muslim patients and offers a number of articles for additional reading. [Added 1/12/16:] See also our January 2016 Article-of-the-Month regarding Muslim patients' practice of *salat* after stroke.
