Research

Chaplaincy and Spiritual Care Services: The Case for Muslim Patients

Wahiba Abu-Ras, Ph.D.¹

Address: ¹Assistant Professor, School of Social Work, Adelphi University, Garden City, NY 11530.

Email: Wahiba Abu-Ras, Ph.D. * - abu-ras@adelphi.edu

Topics in Integrative Health Care 2011, Vol. 2(2)  ID: 2.2002
Published on June 30, 2011 | Link to Document on the Web

ABSTRACT

Religion and spirituality are the first, and sometimes the only available sources of comfort for many hospital patients facing difficult and stressful times. Since chaplaincy is typically practiced along Judeo-Christian lines, other spiritual perspectives receive less attention. This study assesses the existing chaplaincy care services available for Muslim patients as perceived by two different groups, 33 Muslim and non-Muslim chaplains and by 56 directors of chaplaincy departments at New York City hospitals. A mixed-methods approach was used, including a cross-sectional survey and in-depth interviews. The results indicate that Muslim patients’ religious needs may be underserved, and that they may not receive appropriate chaplaincy care. These results may provide a better understanding of the challenges that other immigrants and minority groups face when receiving medical care, and of the need for quality spiritual care for these communities.

INTRODUCTION

Religion, spirituality, and faith provide the majority of Americans with a healthy means of coping with adversity, giving them the ability to recover from difficult events and losses.¹³ Research indicates that religion provides psychological benefits and important social resources.⁴ Several studies show that the healthy practice of one’s faith usually correlates with positive mental and physical health,⁵⁻⁸ both of which are associated with the prevention of illness across divergent religious communities⁴,⁹
Approximately 90% of hospitalized patients within the United States indicate they use religion to cope with illness, and over 40% say it is the most important factor in their struggle for recovery.\textsuperscript{10}

Although there is no definitive link between religious guidance and health, some studies suggest that chaplaincy plays an important role in helping patients cope with physical illness.\textsuperscript{11-12} In its accreditation of hospitals in the US, 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.”\textsuperscript{13, p.15} Spiritual care integrates the body and the soul and, as such, its provision by chaplains is critical in identifying a model for successful patient outcomes. In an increasingly pluralist society such as that of the US, the expectation is that the diverse needs of all faith communities will be met. However, in the US, the predominantly Christian population tends to benefit most from chaplaincy services, while the spiritual needs of other minority religious groups often are not adequately addressed.\textsuperscript{14-16} This trend may reflect a lack of diversity within chaplaincy services, despite the diverse hospital patient populations they serve.

VandeCreek and Lyon\textsuperscript{17} found that a patient’s level of satisfaction increases when chaplains respond to diverse patient concerns in a sensitive manner. However, when a chaplain of a different religious denomination was asked to pray, the patient deemed the prayer to be inappropriate, even when the chaplaincy visit helped the patient address important medical, nursing and administrative issues.\textsuperscript{17} Hamza\textsuperscript{18} supported this finding by noting that the lack of knowledge about minority patients’ spiritual needs, or the existence of ethnic differences between the chaplain and patient, can negatively impact this relationship and its effectiveness.\textsuperscript{15} The ability to meet the needs of all patients is important, not only for the well-being of the patients themselves, but also for the entire hospital staff that seeks to maximize patient satisfaction and foster positive patient relations.

**The Case of Muslim Patients in New York City**

Currently, there are no accurate data about the exact number of Muslims in the US. However, some have estimated that Muslims are the second largest religious group in the world and one of the most rapidly-growing religions in the United States, after Christians,\textsuperscript{18} with census estimates ranging between 5.7 million\textsuperscript{18} and 7 million.\textsuperscript{19} The annual growth rate of this population is 6%, compared to the average national rate of 0.09%, and the Muslim population is expected to double by the year 2014.\textsuperscript{20} Muslims also tend to be more concentrated in urban centers.\textsuperscript{21}

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 by any other US city.\textsuperscript{22} In New York City, there are about 600,000 Muslims,\textsuperscript{23} and they are almost equally represented by three major regional or ethnic groups: African American, Middle Eastern (including Arabs and Persians), and South Asian (mostly Pakistanis and Indians).\textsuperscript{24} These diverse groups signify a wide spectrum of religious practices, adherence, rituals, and traditions. However, their core Islamic worship and theology are remarkably uniform compared to many religions.\textsuperscript{24} 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 five
times each day, fasting during the holy month of Ramadan, giving Zakat (charity), and pilgrimage to Mecca. Many Muslims consider their religion and beliefs to be the most important aspect of their spiritual essence, 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 technological health care system, ethical questions regarding patient care arise frequently. Many Muslim patients draw upon Islamic legal tradition and religious scriptures for guidance when making difficult decisions, including whether to continue aggressive treatment, participate in family planning, or receive or donate organs. 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.

Racism and discrimination in the US affect many immigrants from non-English-speaking communities. However, the experiences of the Muslim community are exceptionally different for several reasons. Most Muslims have experienced religious discrimination, a problem that has become endemic since the 9/11 attacks. As a result of the political and social climate in the United States, and particularly in New York City, many Muslims feel further marginalized and are afraid to utilize government services, including health care services. This prompts many American Muslims to use religion and faith as a source of support and a means to cope. In addition, mental health research has demonstrated that American Muslims are more likely to report emotional or psychosocial problems to spiritual leaders, imams (Muslim leaders), and chaplains than to mental health professionals.

While most empirical studies have thus far focused on Judeo-Christian religious populations, the following study is the first to examine and assess existing chaplaincy care services for Muslim patients, as perceived by directors of chaplaincy departments and by both Muslim and non-Muslim chaplains in New York City hospitals. This study also highlights the major barriers Muslim patients face when accessing services in hospitals and health care settings within an urban region, and identifies ways to minimize these barriers as suggested by the study participants.

METHODS

Sample Selection and Recruitment Procedures

The study uses mixed methods, comprised of a cross-sectional survey administered to 56 hospital pastoral care directors (from this point on referred to as directors) and a series of in-depth, semi-structured interviews with 33 Muslim and non-Muslim hospital chaplains (from this point on referred to as chaplains) in hospitals and health care settings within the five boroughs of New York City (Manhattan, Brooklyn, Bronx, Queens, and Staten Island). The survey and the semi-structured questionnaire used in the face-to-face interviews were developed by the investigator specifically for this study, to gather data on the: a) New York City hospitals and health care settings’ socio-demographics; b) chaplains’ socio-
demographics; c) availability and access to pastoral and spiritual care services among Muslim patients compared to non-Muslim patients; and d) perception of the chaplains and directors with respect to the major barriers Muslim patients face in the utilization of pastoral services.

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 hospitals’ websites. A survey questionnaire and an invitation letter were mailed to all 85 potential directors inviting them to take part in the study. Six surveys were returned with incorrect addresses, and 56 surveys were completed and returned, for a response rate of 71%.

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.

**Statistical Analysis**

Prior to data analysis, measures of central tendency and variability and histograms were generated for all variables to examine outlier cases and skewness coefficients. 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 as shown in Tables 1 and 2. Descriptive univariate analysis was used to analyze the quantitative data. For the qualitative data, a grounded thematic approach was employed to analyze transcripts of all interviews using the computer-assisted qualitative data analysis software package, ATLAS.ti (2008). Based on the thematic findings of this question, all participants’ responses were compared and contrasted.

**RESULTS**

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 the directors (56%, n = 28) and the chaplains (70%, n = 23) were male, and 66% of the participants held a Master’s degree or higher, sharing 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, most in non-profit institutions. 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. According to the Association of Professional Chaplains (www.professionalchaplains.org), board-certified chaplains have demonstrated professional excellence as a chaplain, met 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), received ecclesiastical endorsement by a recognized faith group, been recommended by a Certification Committee, approved by the commission on Certification, and ratified by the Board of Chaplaincy Certification Inc. Board of Directors.

The vast majority (91%, n = 21) of the non-Muslim chaplains were employed full time and paid directly by their hospitals, while two of the 10 Muslim chaplains were employed full time but paid directly by the state of New York. Fifty percent (n = 5) identified themselves as imams and worked as part time chaplains. One imam worked as a volunteer, one was paid per-diem, and one was an intern in training.

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 daily patients census by faith 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) (Table 1).

Table 1. Hospital Size: Licensed Bed, and Average Daily Patients Census (AD PC) Per Hospital in General and by Region

<table>
<thead>
<tr>
<th>Average Patient Census, by hospital in general &amp; by faith</th>
<th>Total N</th>
<th>Mean (S.D.)</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Licensed bed</td>
<td>52</td>
<td>447 (259.7)</td>
<td>100-200</td>
</tr>
<tr>
<td>General ADPC</td>
<td>43</td>
<td>241 (167.4)</td>
<td>30-693</td>
</tr>
<tr>
<td>Christian ADPC</td>
<td>43</td>
<td>50 (66.1)</td>
<td>0-285</td>
</tr>
<tr>
<td>Jewish ADPC</td>
<td>42</td>
<td>61 (78.8)</td>
<td>0-403</td>
</tr>
<tr>
<td>Muslim ADPC</td>
<td>43</td>
<td>17 (19.7)</td>
<td>0-90</td>
</tr>
<tr>
<td>Other ADPC</td>
<td>42</td>
<td>16 (14.3)</td>
<td>0-60</td>
</tr>
<tr>
<td>Total Muslim patients served per year by hospitals **</td>
<td>34</td>
<td>130 (338.2)</td>
<td>0-1800</td>
</tr>
</tbody>
</table>

**39% (n=22) of the 56 hospital directors did not have statistics about Muslim patients or they are unaware/unsure
Ninety-one percent (n = 49) of 54 responding directors employed paid chaplains; 75% (n = 35) of 48 reported to 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 5 full-time paid chaplains, and 47% (n = 22) hired up to 10 unpaid volunteer chaplains.

Based on the survey results of the directors, paid and volunteer Christian chaplains had the highest median of 2 (mean = 3, SD = 4.0), and 4 (mean= 9, SD = 13.61), respectively. The median for paid and volunteer Jewish chaplains was one, (mean = 1, SD = 0.8), with Muslim paid and volunteer chaplains (median = 0, mean = 0.3, SD = .48; median = 0, mean = .67, SD = 1.1) and those of other faiths paid and volunteers (median = 0, mean = .2, SD = .5; median = 0, mean = 1.25, SD = 2.2), respectively, lagging far behind (Table 2).

**Table 2: Mean Number of Employed Professional Chaplains (EPC) and Volunteer Chaplains (VC) By Faith**

<table>
<thead>
<tr>
<th>Number of EPI by faith</th>
<th>Total N</th>
<th>Mean</th>
<th>S.D.</th>
<th>Range¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christians</td>
<td>52</td>
<td>3</td>
<td>4</td>
<td>0-21</td>
</tr>
<tr>
<td>Jews</td>
<td>51</td>
<td>1</td>
<td>.8</td>
<td>0-4</td>
</tr>
<tr>
<td>Muslims</td>
<td>49</td>
<td>.3</td>
<td>.5</td>
<td>0-1.5</td>
</tr>
<tr>
<td>Other</td>
<td>49</td>
<td>.2</td>
<td>.5</td>
<td>0-2.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of unpaid VC by faith</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christians</td>
</tr>
<tr>
<td>Jews</td>
</tr>
<tr>
<td>Muslims</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

¹¹= full-time; 0.5= part-time
About one-third (35%, n = 17) of 51 responding directors reported that Muslim patients were served by imams, while 27% (n = 14) reported that they did not know or were unsure how the Muslim patients were served, or the data was otherwise unavailable.

The availability of adequate prayer space for all faiths was reported by 84% (n = 42) of 56 responding directors: slightly more than half (51%, n = 28) conducted Friday prayer services for Muslims, 40% (n = 22) reported that their prayer services were not conducted by a chaplain, and 9% reported that they did not know if services were held.

### Major Barriers in Serving Muslim Patients

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 and stigmatization among Muslim patients, the practice of chaplaincy through a Christian framework, lack of trained Muslim chaplains and access to community resources that support Muslim patients, and lack of awareness among Muslim patients of the existing chaplaincy services.

All chaplains described similar barriers to those reported by the directors, and even cited others. For example, non-Muslim chaplains articulated vulnerability, a lack of identification between chaplain and patient, and Muslim patients’ fear of discrimination after 9/11 as major barriers to care. One chaplain stated: “The barriers are related to vulnerability. In New York City, in this climate post 9/11, everyone tiptoes around the concern of stereotyping. When you’re on the receiving end and you’re sick, you are vulnerable. It [even] happens with the staff - American patients may not want Islamic staff and vice versa. Islamic patients may not even identify themselves as Islamic for fear of being treated badly. [We] get very vulnerable [sick] people in this hospital. When you add the cultural stereotypes, they are even more vulnerable.” Some non-Muslim chaplains claimed that Muslims generally do not trust non-Muslims. One linked this distrust to foreignness: “One time a Muslim patient did not want anyone in. This patient had the most foreign-looking family than anyone in the hospital.” Muslim patients have also expressed a fear of being proselytized by non-Muslim chaplains; one chaplain spoke of being rejected by a Muslim woman because she thought Christians “believed in three gods.” Another suggested that a barrier for many chaplains is the Muslim rejection of interaction with people of the opposite sex.

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. They cite instances of Muslims who eventually responded to them across gender and language barriers because of their Clinical Pastoral Education training on managing patients, or, in the case of Muslim chaplains, because of their Islamic affiliation. Clinical Pastoral Education (CPE) is interfaith, professional education for ministry. It brings theological students, qualified laypersons, and ministers of all faiths (pastors, priests, rabbis, imams, and others) into supervised encounter with persons in crisis.

One Muslim chaplain stated, however, that these barriers are easier to overcome for imams. He said:
“Once a chaplain was making the rounds and visited a female Muslim patient. He felt that she was not being receptive to him. He [the non-Muslim chaplain] informed her that there was an imam here, and she wanted to see him.”

At least three non-Muslim chaplains admit to experiencing barriers from their perspective. A chaplain wondered if his “being Catholic is also a barrier,” citing his “lack of knowledge, lack of specific training in Muslim culture and prayer, [and lack of] comfort level with prayers.” The result is that he has only “casual conversation, nothing more” with Muslim patients. Another chaplain reports her unease with some Muslim practices: “Sometimes they have women with the whole black covering where just the eyes are showing—burqa? This is the only thing that gives me an odd feeling. I find it repressive and oppressive.” Another chaplain expressed his personal biases towards Arabs and Muslims regarding politics and religion. “If you read the Qur’an, and I never read it, but I read about it, Mohammad himself killed a whole Jewish community. But there is no animosity towards them, and on a professional level, I am a chaplain, and there to take care of their spiritual needs. I am there to help everyone.”

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. “It’s very hard to get [Muslim] clergy to comply with specific health care clearance, such as a TB test. An imam will say that he’s happy to come by, but can’t be bothered with this stuff. The lay people comply; the clergy don’t.” One chaplain contrasted chaplains and imams: “A cleric’s job is to defend the faith. A chaplain’s job is to defend the faithful. We look at the needs of the patient in relation to illness. Hopefully we help strengthen them. We don’t take faith and beat them up with it.” A Muslim chaplain explains the need for trained Muslim chaplains: “We need to get more clinically trained Muslims—not necessarily imams—board-certified. They need some clinical training. They need to meet people where they are in their illnesses. They need to leave out biases, and realize the difference between culture and religion. There are different cultures but one religion.”

**Cultural Competency Training**

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. Several reported that cultural competency training is part of Clinical Pastoral Education or pastoral training, which taught them to treat people from all religious traditions equally. It emphasized asking questions and listening to patients to learn about Islam. Nearly all associated ‘cultural competency training’ with gaining knowledge about specific beliefs and practices of people whose traditions are different from their own. Others used a more informal approach, took the initiative themselves to learn, relied on internet resources, or consulted regularly with Muslim relatives or local imams to learn more about Islam and Muslim patients’ needs. One spoke about Muslim physicians who served as cultural educators at the hospital or as consultants to the pastoral care staff. Two indicated that their hospitals offered in-service training opportunities specifically addressing Muslim patients’ needs.
DISCUSSION

The majority of directors reported that their hospitals employed up to 5 board-certified chaplains with the highest mean of 3 certified, while the findings from the interviews indicated that one-third of chaplains were board-certified, including one Muslim chaplain. This discrepancy may explain the fact that hospital chaplaincy programs may not be totally capable of meeting the challenges of an increasingly diverse patient population, and one that requires knowledge of multiculturalism. Common perceptions of hospital chaplaincy departments are that they are understaffed, lacking in status and often poorly integrated with other hospital programs; they are essentially services provided without an associated revenue stream. Chaplaincy organizations often argue that spiritual care provision in most hospitals is woefully inadequate. To assess the gaps, hospitals must determine which group of patients are receiving adequate spiritual care, which are not, and the reasons for any possible discrepancy.

The 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 (including Hindus, Buddhist, or patients with no specific religious affiliations) were 0: 11.5 and 0: 12, respectively. This finding suggests that hospitals may be providing unequal chaplaincy services, with a bias in favor of Christian patients compared to all other patients of different faiths. Regarding Muslim patients in New York City hospitals, many directors reported no knowledge of the number of Muslim patients in their hospitals while having ready estimates of the number of Christian and Jewish patients. Of those with estimates, they reported an average range of 0 to 90 Muslim patients. One explanation for this is that hospitals may not collect or distribute adequate data on the religious affiliation of patients who are neither Christian nor Jewish. An examination of intake forms and admitting practices would help determine if they identify specific ‘other’ religious groups. There may also be a gap in communicating a patient’s religious affiliation to chaplaincy departments. Further investigation may identify triaging practices by which chaplaincy departments manage their workload. Another interpretation for the low or unknown number of Muslim patients is that Muslims, like many immigrants, are not hospitalized in numbers proportionate to their presence within the population. Studies have shown that overall, immigrants have less health insurance, receive lower quality of care, and use health care services less than US-born populations. Some studies attribute this to the fact that immigrant populations tend to be younger and in better health, or have immigration status issues that prevent them from accessing healthcare. Directors also expressed confidence in accommodating patients’ needs by accessing a local clergy member upon request. This service may very well fill the gap resulting from understaffed chaplaincy departments or undertrained chaplains and must be publicized to patients upon admission to the hospital; many immigrant Muslims were found to have unfamiliarity with existing services in general.
and chaplaincy in particular. But the qualifications of the local clergy members also must be considered; in the case of Muslim patients, the concept of clergy is actually nonexistent since imams are traditionally leaders of prayer, and is only loosely translated into “clergy” in Western societies. Imams may also need to be trained in chaplaincy to comply with hospital regulations.

In turn, Muslim patients may resist any special services from chaplains due to fear of discrimination, especially since 9/11. Several non-Muslim chaplains said that Muslim patients tend to refuse, reject, or mistrust services offered to them. These chaplains attribute such rejection and distrust to several factors, including the “foreignness” of some Muslim families, fear of “being proselytized by non-Muslim chaplains,” Muslim perceptions that “Christians are not monotheists,” and rejection of “interaction with people of the opposite sex.” When Muslim patients mistrust or refuse services offered by Christian or Jewish chaplains, the latter may be less likely to offer services to Muslim patients in the future due to the lack of engagement with these patients. The data suggest that chaplains may also interpret such refusal to mean that Muslims do not need or want chaplaincy services.

Some chaplains believed that a Muslim patient’s family will tend to the patient exclusively and provide the necessary care without seeking chaplaincy services. This belief is likely to be based on the fact that in most Muslim societies, members do value close extended family ties, which may serve as a strong social support system for a patient. However, many American Muslim immigrants or converts lack familial support systems because of immigration barriers, economic reasons, religious differences within families, and alienation from family and friends, in the case of converts. The belief that family provides the necessary spiritual care for Muslim patients could deter outreach towards Muslim patients who may need chaplaincy services.

When patients do not receive the level of spiritual and religious care that they require or need, the physical healing process may be limited. Thus, hospitals may face challenges beyond the medical conditions they seek to treat. The provision of professional and culturally competent spiritual care becomes intrinsic to hospital care and knowledge of the demand for and utilization of these services is imperative. In the case of highly dense Muslim populations in a city like New York, the general lack of data suggests that an appropriate needs assessment be made and that further studies are required to address this knowledge gap.

Lack of access to trained imams and language barriers between patients and chaplains were among the major barriers articulated by the directors and the chaplains. Most chaplains in hospitals are Christian clergy, yet many of these clergy members are not trained in pastoral care skills such as providing spiritual assessment, interfaith conversation, and grief counselling to non-Christian patients. If hospitals hire more trained chaplains, would these chaplains be able to provide spiritual care to all those in need, and be trained to mobilize spiritual resources so that patients cope more effectively? This question suggests that professional or certified chaplains are not only trained to discuss patient concerns or provide religious guidance, but also to provide a more supportive context within which patients can discuss their concerns and maintain their confidentiality. Based on VandeCreek and Burton’s (2001) definition, certified chaplains are accountable to religious faith groups, the certifying
chaplaincy organization, their employing institution, and, most importantly, they must demonstrate a deep commitment and sensitivity to the diverse ethnic and religious cultures found in the American society. This does not mean that professional chaplains should replace clergy. However, they might be more useful in intense medical environments, especially in the face of medical issues that involve end-of-life treatment choices. Chaplaincy, in recognition of the diversity of religious rituals related to illness and end-of-life practices, seeks to continually strengthen its knowledge base in order to provide the most effective services possible. As more hospitals and other health-care institutions acknowledge the importance of spiritual care, there is increasing demand for chaplains and clergy members who can meet all patients’ spiritual and religious needs.

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, Membership Coordinator of the Association of Professional Chaplains, 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.

According to the New York City Health and Hospitals Corporation (2006), there are 1.3 million New Yorkers speaking more than 100 languages who are being served in New York City hospitals. Despite the diverse hospital staff and the telephone translators in New York City hospitals, many directors cited language as a barrier to serving Muslim patients. These directors may be referring to the many languages that the Muslim immigrant population speaks and also to the Arabic prayers that all Muslims recite regardless of ethnicity. Chaplains may rightfully feel that they are unable to communicate or pray with the patients they are serving.

Several directors and chaplains also acknowledged their lack of education and the awareness of Islam, doubts about their ability to discern Muslim needs, and their prejudices about the culture. Some spoke of the “political tension” around Jewish-Muslim relations with regard to the Israeli-Palestinian conflict as another obstacle to open relationships in chaplaincy care. While these attitudes are acknowledged, they may still result in unequal care being provided to all minorities and immigrants. Several studies demonstrate that minority patients perceived higher levels of discrimination in the health care industry than non-minorities and this perception may very well lead to patient resistance, thus causing a self-propelling cycle.

The results of this study raise two major questions. First, what changes should hospitals’ chaplaincy services systems make to recognize the equal value of different religions and cultures? And second, how can chaplains accommodate other minority and ethnic groups’ interests, such as the Muslim patients, without using a uniform approach? Further studies are necessary to address these issues.
Limitations

The findings of this study should be interpreted in light of the following limitations. The study relied on a small, non-random sample of 56 directors and 33 chaplains, and a sample of imams who are mostly untrained but serve as chaplains, limited to the five boroughs of New York City. The list of participants were contacted exclusively from a list provided by The Health Care Chaplaincy and from hospitals’ websites, and excluded other potential community organizations such as mosques and Islamic schools. In addition, the study was conducted in English and excluded non-English-speaking chaplains. Future studies on Muslim spiritual needs should also include the perspectives of patients. The transcripts were analyzed by one coder, which introduces the possibility of subjective bias in interpreting the data. With greater accuracy in recording, a finer analysis of chaplains’ discourse about Muslim patients would be possible. The author recognizes that attitudes, opinions, and experiences may be shaped by degrees of experience and exposure to Muslim patients, and did not attempt to analyze the organization and triaging practices of chaplaincy services in the study sample. Future studies should better control for ethnicity and other individual backgrounds within the Muslim community. There may be factors, in terms of size and composition of the healthcare system, chaplaincy staffing, and Muslim patient population that are unique to New York City. These limitations potentially constrained the author from making generalizations based on the findings because the data may not be representative of other subject populations. A more comprehensive national study could illuminate these factors more clearly.

Acknowledgements

This study was funded by the Institute for Social Policy and Understanding and by the Muslim Mental Health Inc. The author would like to thank Dr. Lance Laird for his helpful comments, and Ms. Tricia Moscato for her assistance in reviewing and editing this manuscript.

References


