Introduction

Spiritual care and visitation of the sick have deep roots in Islamic tradition as expressions of worship (‘ibadat) and ethical (mu’ammalat, adab) obligations. This type of care, however, has traditionally been a general responsibility of all Muslim individuals and families, rather than of a specialized few. The phenomenon now recognizable as professional Muslim chaplaincy in public institutions emerged gradually in the United States and the United Kingdom beginning in the 1960s and 1970s. Early volunteer efforts were haphazard or ad hoc attempts to provide for the religious needs of Muslim prison inmates, hospital patients, and later university students and military personnel. Similar developments in Denmark and Australia occurred in the 1990s (Baig 2011; ISRA 2018). While Muslim chaplains are active in German, Dutch, and French military and correctional facilities (Bertossi 2013; Harms-Dalibon 2017; Alouane 2019), little data is available on the involvement of Muslim healthcare chaplains in these settings (Sargent and Erikson 2013). In many Muslim majority countries, spiritual care is provided by volunteers or other healthcare professionals (Herlianita et al. 2018; Loh 2013; Abu-Shamsieh 2013). Kamal Abu Shamsieh, a chaplain and founder of the non-profit organization, Ziyara, has developed Muslim chaplaincy services and has conducted training internationally in Oman, Indonesia, Jordan, Malaysia, Saudi Arabia, and Pakistan (2019). Other American healthcare chaplains have also presented their model of spiritual care in Muslim majority countries (Chaplain Tahara Akmal, personal communication).

The present chapter will outline the contours of this emerging profession of Muslim healthcare chaplaincy. We synthesize prior work on Muslim chaplaincy in the United Kingdom with recent social scientific studies on Muslim chaplaincy in North America and Europe. We supplement these sources with our ongoing qualitative survey and interview study of Muslim healthcare chaplains in the United States.1 We examine practical theological writings of Muslim chaplains as they locate their practice in Islamic tradition, while we explore questions about Protestant hegemony in spiritual care training and practice. Chaplaincy has provided Muslim women with new opportunities for religious leadership, while also opening doors for a visible Muslim presence in public interfaith service. While especially significant for Muslim minority communities in the West, as professional healthcare chaplaincy emerges in Muslim

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Professionalizing a communal obligation

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majority contexts, the practical theological dialogue among Muslim chaplains may have interesting implications for the understanding of ‘religion’ in ‘public life’ in these settings as well.

Emergence of Muslim healthcare chaplaincy

In the United States, African-American Muslims pioneered spiritual care in prisons, as incarcerated Muslims sought to exercise their civil rights to practice religion, with a focus on halal food, prayer space, fasting during Ramadan, and Eid celebrations. The 1960s and 1970s brought demographic changes in the American Muslim community that spurred the growth of professional leadership. The 1965 Hart-Celler Act increased immigration to the US from Muslim majority regions, including the Middle East and South Asia. The mid-1970s’ transformation of the majority of the Nation of Islam to a Sunni Muslim movement under the leadership of Imam W.D. Mohammed brought further growth in African-American Muslim communities. Muslim organizations, congregations, and institutions proliferated, and an emerging cadre of Muslim professionals began taking a more active role in American secular and religious life (Yuskaev and Stark 2014).

Similarly, in the UK, from the 1970s to the 1990s, Muslim spiritual care in prisons and hospitals consisted of local efforts to meet the basic religious needs of patients and incarcerated persons. According to Gilliat-Ray and Ali (2016), since many immigrant imams could not speak English well, Muslim professionals, including physicians, functioned as ‘visiting ministers.’ The 1990s, they suggest, witnessed key social shifts that encouraged the growth of Muslim chaplaincy. The 1991 Patient’s Charter for the National Health Service (NHS), coupled with a growing Muslim patient population, sparked hospitals to seek part- or full-time Muslim chaplains to meet ‘spiritual and religious needs.’ Maturing immigrant Muslim communities, led by British-trained seminary graduates, began interacting with the health system on a regular basis. British chaplaincy organizations began to develop more inclusive structures, gradually moving from Christian chaplains ‘trained’ to provide spiritual care for Muslim patients to hiring Muslim spiritual care providers educated in Christian institutions. A major factor, however, in the development of Muslim healthcare chaplaincy that distinguishes the British from the US case is state funding of positions (Gilliat-Ray and Ali 2016). State funding of chaplaincy positions imposes greater standardization of training requirements across the healthcare system, whereas US private hospitals can organize spiritual care through a variety of arrangements and hire chaplains with a range of qualifications.

In Denmark, Muslim spiritual care providers emerged more recently. Though Turkish and Pakistani immigrants began settling in Denmark in the late 1960s, it was not until 2006 that the first Muslim volunteer healthcare chaplain was appointed to two Copenhagen hospitals. This occurred after Christian chaplains had expressed the need for Muslim assistants for immigrant Turkish and Pakistani patients. They approached the Centre for Co-existence—Islamic-Christian Study Centre (IKS) for assistance (Center for Sameksistens 2019). The latter created an ‘Ethnic Resource Team’ to serve as a volunteer visiting corps for ethnic minorities on the basis of language and nationality. This team assisted the state church (Folkekirken) Lutheran-Christian chaplaincy services at Copenhagen hospitals from 2008–2010. Nearly one-third of their patients were Muslims who requested an imam’s help with questions of death, including funeral rites or end-of-life care, as well as abortion and organ donation decisions. Muslim chaplaincy is beginning to gain a foothold, but questions of community or state funding, training opportunities, and a political climate suspicious of multifaith and multicultural efforts present challenges (Baig 2011). The European Network of Healthcare Chaplains indicates that similar efforts to educate and employ trained Muslim chaplains have emerged in Germany,
Sweden, Switzerland, and France (ENHCC 2019; Universität Freiburg 2019). Still more recently, Muslim communities in Australia have begun to train chaplains in connection with university hospital programmes (ISRA 2018).

While chaplaincy training programmes are gradually emerging in Muslim majority countries, there is some evidence of religious leaders and health professionals providing spiritual care (Herlianita et al. 2018; Tirgari et al. 2013; Ozbasaran et al. 2011; Melhem et al. 2016). Gilliat-Ray and Ali identified an imam serving as chaplain to the National Heart Institute of Malaysia who attracted attention when he publicly encouraged organ donation, a subject of some debate among experts in Islamic law and bioethics (Gilliat-Ray and Ali 2016; cf. Abusaif 2007). Engagement with bioethical debates in medicine is one of the entry points for the development of Muslim healthcare chaplaincy, beyond spiritual care provision. In 2019, referencing hospital chaplaincy training and accreditation in the US and UK, the Malaysian government announced that it is developing curricula for spiritual guidance degrees in partnership with local universities (Star Online 2019).

As in the case of Muslim prison chaplaincy in the Netherlands, however, some raise questions about whether the emergence of chaplaincy, particularly in Western state institutions, is adaptation due to pressure from outside the religious tradition or a freely chosen re-contextualization of that tradition (Ajouaou and Bernts 2015). The export of a European and North American model of healthcare chaplaincy to Muslim majority countries may present similar opportunities to examine the relations of religion, state, individual, and collective rights and duties (Harms-Dalibon 2017).

Grounding healthcare chaplaincy in Islamic tradition

Though most Muslim healthcare chaplains in the West are educated in historically Protestant Christian institutions, they tap a deep well of resources from within their own tradition to legitimize, provide an ethical framework for, and make meaning of their work. Several Muslim chaplains have written about ‘chaplaincy’ as a recovery of traditional Islamic beliefs about illness, healing, practices of care, and conceptions of community that they map onto new, institutionalized forms of care. Such interplay between Islamic traditions and healing professions can be understood contextually as fitting into a long history of ‘Islamic medicine.’

Muslim patients and healthcare providers are generally unfamiliar with the term ‘chaplaincy,’ though once explained, many find that the roles and activities of a chaplain are familiar. For example, a survey of Muslims at a California hospital found that 44 per cent would want a prayer or supplication (du’a) from an imam, chaplain, or volunteer (Abu-Shamsieh 2012: 73). Muslim healthcare chaplains in our recent study consistently cited Qur’anic verses and hadith to legitimize their practice to others as well as to themselves. One chaplain paraphrases part of a Qur’anic verse (3:159): ‘It’s by the mercy of Allah that you were gentle with them because had you been harsh or hardhearted, people would have fled.’ This chaplain tries to embody this ‘sense of prophetic gentleness, care, and tenderness.’ He describes chaplaincy as a ‘vehicle’ for actualizing the prophetic example of mercy, for helping people cultivate their lateral relationships with others, and their transcendent relationship with their Lord. He alludes to concepts understood by his fellow Muslims as ‘ibada (worship of God) and muamalat (human interaction). Many chaplains reference mercy in their reflections: mercy being renewed, restored, and recreated through each encounter (Abdul Majid et al. 2019).
A hadith that resonates with healthcare chaplaincy is the hadith qudsi (divine hadith) about finding God with the sick. Abu Huraira, a companion of the Prophet (pbuh), reported him as saying:

God shall say on the Day of Judgment, ‘O son of Adam! I was sick but you did not visit me.’ ‘My Lord how could I visit you when you are the Lord of the whole world,’ man will reply. God will say, ‘Did you not know that so and so from among my servants [that is, human beings] was sick but you never visited him or her? Did you know that if you had visited, you would have found me there?’

(quoted in Rahman 1998: 59)

The reward of such visits is high; Caliph Ali ibn Abu Talib narrated that he heard the Prophet (pbuh) saying: ‘No Muslim visits a [sick] Muslim in the morning without 70,000 angels sending salutations upon him until the evening; and if he visits him in the evening, 70,000 angels send salutations upon him until the morning. And he will be rewarded with the fruits of Paradise’ (Nawawi 1990, Hadith 899).

Visiting the sick, iyadah, approached with rifq, exemplary kindness/care, is an important aspect of spiritual care in Islam, when offered in the optimal state of ihsan, doing what is beautiful. In Sufi writings on Muslim spiritual development, ihsan ‘points to a state of vigilance and deep self-awareness also known as “muraqaba” that is essential in spiritual care work’ (Baig 2007). Effective and fruitful sohba, companionship and presence, happens when uplifting comfort, inspiration, love, encouragement, strength, exhortation to fortitude and healing are achieved (Isgandarova 2011: 19).

In one of the first publications in English on Islam and medicine, modernist Muslim thinker Fazlur Rahman articulated an Islamic ethical paradigm in the inextricable coupling of faith and action. He explained in the context of Qur’anic surah 107, al-Ma’un, that ‘without positive works of social weal and alleviation of suffering, prayers [in worship of God] are a mere farce’ (Rahman 1987: 30). According to a popular hadith, even half a date and a kind word are charity (Nawawi 1990, Hadith 693). Positive works, faith, and action, according to Rahman, are manifest in the founding of institutions such as hospitals, hospices, schools, and universities.

In the contemporary US, three-quarters of Muslim chaplains serve both Muslims and non-Muslims (Laird and Abdul Majid 2019), sparking reflection on the theological and legal basis for interfaith spiritual care. A hadith story recounts that the Prophet visited an elderly woman when she became ill, despite the fact that she had thrown rubbish on him daily. Isgandarova interprets this to mean that compassionate care is not circumscribed by religion, gender, or friendship (2011: 20). Openness and inclusion were the modus operandi of hospitals in Islamic history, open to all irrespective of religion or ability to pay. Concern for spirituality was manifested in the presence of both mosques and chapels, as in the thirteenth century Mansuri hospital in Cairo (Rahman 1987: 70).

Drawing upon the Qur’an and the hadith literature, this integration of philosophy, science, and Islamic legal and ethical tradition in the service of spiritual care continues the legacy of Islamic medicine (see Alavi, ‘Unani medicine,’ this volume), uniting the ‘organic body’ and the ‘life force’ (ruh) in treating disease (Nagamia 2003: 29). Isgandarova and Min summarize: ‘Historically, effective Islamic spiritual and religious care and counselling is grounded in a holistic perspective that, ideally, human beings are integrated composites of physiological, psychological, spiritual components’ (Isgandarova and Min 2014: 2).
In contemporary hospital settings, Muslim chaplains face challenges observing their tradition while adapting rituals and etiquette to meet the needs of their patients, especially non-Muslims. They devise ways that are meaningful to the patients or families while maintaining their authenticity. For example, instead of performing baptism for a Christian child, a Muslim chaplain may coach a family member to do so. Others worry about breaching norms. For instance, a distraught Buddhist woman facing surgery asked for a hug from a male Muslim chaplain, who typically resisted even shaking hands with women. He struggled internally, then hugged her. Worried that he had violated the moral standards of his own tradition, he consulted a senior imam. The imam reflected on compassion and humanity and replied, ‘If you didn’t hug that woman at that moment, I would just tell you this job is not for you’ (Abdul Majid et al. 2019). In both small and large ways, chaplains interpret and adapt their tradition every day. Gilliat-Ray and Ali describe these processes as ‘practical *ijtihad*,’ referring to the tradition of legal reasoning often reserved for highly specialized jurisprudents, or scholars of *fiqh*. They report a prominent American imam and chaplain calling for ‘contextual *fiqh*’ (al-*Fiqh al-Waqi*) or ‘particular *fiqh*’ (al-*Fiqh al-Aam wal Khas*), as opposed to a general understanding of *fiqh*.

In the context of spiritual care, they encourage chaplains to take into account dominant culture, subcultures, and individual needs as they shift from the letter to the spirit of the law (*maqasid al-shari’ah*, literally, the goals of Islamic law) (Gilliat-Ray and Ali 2016: 158). Muslim chaplains also translate between Islamic concepts and language familiar to non-Muslim peers in the chaplaincy profession. Some Muslim chaplains respond defensively to assertions among some scholars that the term ‘pastoral care . . . refers to the Christian and Jewish religious traditions’ (Doehring 2006: 6) and implicitly ‘cannot include Islam or the spiritual care provided by Muslim chaplains’ Long and Ansari argue instead that pastoral care is Islamic and a ‘spiritually rich way to describe the care offered by Muslim chaplains who journey beside individuals as they traverse the valleys and “mountain tops” of their life’s journey’ (Long and Ansari 2018: 111). Ansari, newly appointed co-director of Hartford Seminary’s Islamic Chaplaincy Program, identified several possible reasons for the exclusion of Islam: simple ignorance ‘of the development of the notion of the shepherd’s work in the care of the flock into a system of the care of the souls in the Islamic tradition’; or, alternatively, ‘an example of the effects of orientalism’ (Ansari 2019: 2). Muslim chaplains provide pastoral care, asserts Ansari, ‘not as an accretion of Judeo-Christian based chaplaincy, nor an imposition from the Judeo-Christian tradition of chaplaincy, but in fulfilment of a Qur’anic imperative to the Muslim religious leader’ (2019: 3). What is new is the professionalization of chaplaincy as more Muslim chaplains engage in public institutions.

Similarly, University of Toronto chaplain Amjad Tarsin examines a narration of the Prophet’s (pbuh) meeting with a young man who sought counsel on fornication. The Prophet (pbuh) offered pastoral care: active listening, unconditional positive regard, and provision of sincere advice. He noted the root meaning of the Arabic word *nasiha* (sincere advice) as to make something whole, which in chaplaincy is to bring wholeness to the soul of the person seeking counsel (Tarsin 2012: 58). Citing Michael Nichols’ *The Lost Art of Listening* (1995) and Donald Capps’ *Giving Counsel: A Minister’s Guidebook* (2001), Tarsin interpolates the requirements of good listening—attention, appreciation, and affirmation—into the Prophet’s (pbuh) stance, demeanor and approach in his interaction with the young man (Tarsin 2012: 38).

Several other Muslim chaplain authors call for training of Muslim religious leaders, including imams, in the social sciences to enhance integration of pastoral care and counseling into traditional Islamic forms of community leadership (Hatim 2017; Isgandarova and Min 2014). Hatim, an African-American Muslim chaplain pioneer and mental health counsellor, encourages exploring what Anton Boisen termed the ‘living human document’ (Boisen 1936: 22)—the
lived human experience—of each Muslim (Hatim 2017: 28). He also relates Pruyser’s seven variables for spiritual assessment in *The Minister as Diagnostician* (Pruyser 1976) to Qur’anic principles. For each variable, Hatim cites three Qur’anic verses and suggests areas to explore or engage with the client. For example, for the faith variable, he cites Qur’anic verses: 48:4–5 concerning increasing faith and tranquillity; 2:6–7 about rejection of faith; and 9:71 regarding obligations of people of faith. Hatim considers faith ‘part of a conversation’ with the Divine. Some experience the ‘feelings of faith’ during prayer or communion with others, separation from which can bring about isolation and feelings of lost faith. He suggests exploring, among other things, the role of faith in the person’s life, and challenges and conflicts of belief (Hatim 2017: 149–155). Chaplaincy thus represents an extension of the legacy of Islamic medicine, which historically integrated disparate sources of medical knowledge from Galenic, Ayurvedic, Chinese, diverse philosophical sources, and local healing traditions within an Islamic worldview (Pormann and Savage-Smith 2007, cf. Alavi, ‘Unani,’ this volume).

**Education, professionalization, and Protestant hegemony**

Job descriptions for professional chaplains generally refer to two different types of qualifications: adequate educational background in one’s religious tradition, and training in pastoral care or counselling (Khalil and Ibrahim 2018). The professional expertise of chaplains rests on both, and yet the means for Muslim minorities in the West to develop authoritative knowledge, credibility, and legitimacy both within the Muslim community and within state or private institutions are highly ambiguous and contested. Several authors note that education and professionalization are developing at different paces in different settings. Key questions revolve around recognition of authoritative and legitimate educational preparation in Islamic tradition and requisite professional standards for different institutions that employ chaplains.

Professional education is the first pillar of chaplaincy. Most Muslim chaplaincy has evolved from volunteer efforts by Muslim lay leaders and concerned members of local communities. The UK-based ‘Faith Matters’ organization contends that, while pastoral or religious care has been a general responsibility in Muslim tradition, today:

> Muslim chaplains start to take responsibility for pastoral care of a whole community . . . within a multifaith context, providing specialist input to help ensure the spiritual, cultural, and religious needs of Muslim communities are met as part of the public sector’s commitment to meet the needs of all communities.

*(Faith Matters 2010)*

Calls for trained Muslim chaplains, as differentiated from imams, have come from other European countries, either from the public sector or from Muslim organizations themselves. Often prisons or hospitals have relied on local imams to serve on an ad hoc basis, though many of these imams were trained abroad or lacked fluency in the host country language. Cultural fluency, interfaith literacy, and the ability to navigate public and secular institutions are important skills that professional Muslim chaplains use to form bridges between Muslim communities, imams, and healthcare institutions.

In order to address the felt need for trained Muslim chaplains, some Western European countries have hosted university programmes for training imams and chaplains (Gilliat-Ray and Ali 2016). In the United States, the Hartford Seminary, a Christian theological school in Connecticut, founded its flagship graduate certificate programme in Islamic Chaplaincy in 1999. A similar programme emerged in 2003 at the Markfield Institution of Higher Education.
in Leicester, England, where both British and Danish Muslim chaplains have trained (Gilliat-Ray and Ali 2016; Baig 2011). Bayan Claremont in California formed as an Islamic graduate school in 2011, and Emmanuel College of University of Toronto began offering its Muslim studies focus within their Master of Pastoral Studies programme the same year (Jalalzai 2016). The Ecumenical Theological Seminary in Detroit has likewise developed a Muslim chaplaincy programme (Yuskaev and Stark 2014), and the American Islamic College in Chicago is likewise seeking accreditation for a Master of Divinity programme.

German academic and community institutions have likewise begun programmes to train Muslim pastoral care providers. Noting the inadequacy of Christian or neutral spiritual care approaches to serving the needs of Muslim immigrant communities, as well as the lack of pastoral care training for imams, several universities and organizations have developed online and local training programmes (Hauschildt and Ucar 2010; Medical Muslim Bridge 2019). One national Muslim organization, the Deutsche Islam Konferenz (German Islamic Conference) has held several symposia to discuss collaboration with state military, healthcare, and prison institutions, focusing on the role of chaplains, the Islamic basis of pastoral care, and the proper training of both volunteer and staff chaplains (DIK 2016b, 2016a, 2016c). Several German universities, including Munster, Osnabruck, Frankfurt, Tubingen, and Erlangen-Nurnberg, offer Islamic theology programmes (University of Tübingen 2019; Heneghan 2016; Center for Islamic Studies 2019). Still more recently, Muslim communities in Australia have begun to train chaplains. The Islamic Science and Research Academy of Australia began offering clinical pastoral education (CPE) courses in Islamic Chaplaincy in collaboration with the University of New South Wales University and the Royal Melbourne Hospital in 2018 (ISRA 2018).

Many of these hosted programmes arose as a way to build on the reputation and accreditation of existing seminaries—many with complex histories of missionary work in the Muslim world—rather than start an unaccredited Islamic seminary from the ground up (Khalil and Ibrahim 2018). As new Muslim theological schools emerge across the United States (including in Boston, Dallas, Chicago, and Berkeley), many are modelling them after these Protestant-hosted programmes for educating Muslim chaplains. Most of these seminary programmes have offered a range of theological, scriptural, and pastoral care courses, along with at least one unit of CPE (see Cadge and Skaggs, ‘Chaplaincy,’ this volume).

According to our recent survey in the US, nearly 80 per cent of Muslim chaplains had graduate degrees, though their fields of study varied significantly. About 30 per cent held a master of divinity degree or equivalent, and those with undergraduate degrees often majored in religious studies or Islamic studies. Many had achieved certificates or ijazahs in Islamic law (shari'ah), Qur’an recitation, or Sufi initiation. Less than 20 per cent of the respondents had acquired certification specific to the chaplaincy profession, and only six chaplains held Board of Chaplaincy Certification Inc. (BCCI) certification, two of them as CPE educators (Laird and Abdul Majid 2019).

Translation and hegemonic religious models

Sajida Jalalzai provides significant insight into how Muslim chaplains training at liberal Protestant seminaries are ‘translated’ into a normative ‘interfaith chaplaincy’ model (Jalalzai 2016). Protestant Christian forms of theology, religious worship, and practice provide the blueprint for discussion of ‘religion’ in most seminaries and CPE programmes, and Muslim students often struggle to ‘fit’ their own understanding into this paradigm. In one of the first qualitative studies of Muslim healthcare chaplaincy in New York City, Abu-Ras and Laird identified a tension between the interfaith ‘one size fits all’ model of chaplaincy and Muslim
chaplains’ perceptions of specific religious needs. The interfaith model often failed to recognize Muslim patients’ experiences of prejudice and discrimination; and to account for the lack of appropriate training for local Muslim leaders who acted as ad hoc chaplains. The standard approach to chaplaincy as generic interfaith spiritual care, they argued, is based on implicit Protestant models, which might present challenges for many Muslim patients and some Muslim chaplains (Abu-Ras and Laird 2011). Without knowledge of Islamic ritual, ethical, and legal traditions, and without adequate contacts with local religious leaders, non-Muslim interfaith chaplains may assume that Muslim patient or staff needs are generically spiritual (Hamza 2007; Padela et al. 2011).

**State-sponsored training and cultural integration**

Besides academic accreditation, attempts to train imams and chaplains locally or nationally in Western countries have faced a number of other challenges. The most illustrative is the attempt by the Dutch state to organize imam training in state-subsidized Protestant universities. Partially motivated by a concern for the ‘integration’ of Turkish, Moroccan, and Surinamese Muslims who began immigrating to the Netherlands in the 1960s, the government developed a plan to educate imams locally in the 1990s, for the purpose of ‘managing the Muslim communities and educating imams who would preach in accordance with the “Dutch values and norms.”’ The plan took on new life after 9/11, and by 2006, the Vrije University Amsterdam (VU), University of Leiden, and Inholland University had established Islamic theology and imam training programmes. All three programmes have now closed because of high drop-out rates and failure to attract students. The programme at Inholland had cultivated agreements with five Sunni umbrella organizations, but tensions with Turkish and Moroccan government and academic institutions over control of the curriculum led to its failure (Sözeri et al. 2018). Similar attempts in European universities have struggled as well (Schepelern Johansen 2006). The Islamic University of Applied Sciences in Rotterdam now offers a Master in Islamic Spiritual Care (IUR 2017).

**Cultural and linguistic fluency**

The second pillar of chaplain expertise is linguistic and cultural fluency, coupled with the ability to adapt and function within the culture (policies, procedures, and structures) of a state or private institution. While Christian seminaries are not state-supported in the United States, one could make the case that such voluntary religious institutions do the work of ‘integration’ and enculturation into ‘American values and norms.’ The influence of North American academic religious studies and Christian forms of biblical criticism may also inform Muslim students’ approach to their own traditions in ways not easily ‘translated’ into their home communities (Heneghan 2016; Jalalzai 2016).

CPE provides a process for interpersonal psychological and theological reflection and clinical experience, primarily in hospital settings in the US. In response to Gilliat-Ray’s comparison of UK Muslim chaplaincy research results to the US context, the American Chaplain Yusuf Hasan objected to the suggestion that chaplains should be ‘Islamic scholars’ rather than ‘qualified lay persons, regardless of gender or school of thought.’ Rather, he insisted that ‘Clinical Education is very much an integral part of eligibility to be a candidate for board certification in a recognized professional chaplaincy organization in America’ (Hasan 2014). Hasan has often insisted that not only CPE training but a thorough understanding of American culture and an appreciation for the pioneering work of African-American Muslims is a prerequisite...
for effective healthcare chaplaincy in the US (Kowalski and Becker 2015). Most of the US Muslim chaplains with three decades of experience are African-American and draw from the legacy of struggles against slavery, discrimination, and denial of civil rights, as well as culturally relevant forms of religious organization, expression, and professional training (Laird and Abdul Majid 2019; Hatim 2017). Muslim CPE educator Tahara Akmal likewise cites the relevance of her experience growing up in an ‘interfaith’ family (her mother was Catholic, her father, Muslim) as part of her calling to ‘interfaith ministry’ (Akmal 2019). Similarly, Chaplain Bilal Ansari, an American Muslim chaplaincy leader, comes from a ‘long lineage of African American Muslim and Christian religious leaders’ (Yuskaev and Stark 2014). In addition to clinical education and cultural fluency, others insist on education in the social sciences (Isgandarova 2011: 126; Isgandarova and Min 2014; Laird and Abdul Majid 2019) in order to incorporate psychological and sociological perspectives into their pastoral care and to collaborate with social service and healthcare providers.

### Institutional endorsement

In addition to education, whether in secular or religious universities, seminaries, or training programs, Muslim healthcare chaplains are often required by employers to have the endorsement of a recognized religious denominational body. In the United States, the Islamic Society of North America (ISNA) provides institutional endorsement for Muslim chaplains (primarily for prison and military), and Muslim chaplains have developed regional organizations in California and Connecticut.

Both ISNA and the Muslim Endorsement Council [formerly, “of Connecticut”] (MEC) websites describe their purpose and endorsement process. ISNA emphasizes diversity, among other things. For example, its Islamic Chaplaincy Services Department states that its mission is: ‘to accommodate the free exercise of religion by providing spiritual care to all people within American institutions.’ Ecclesiastical endorsement, it explains, is an indication that an ‘individual is spiritually, doctrinally, educationally, and professionally qualified to represent his/her faith community in a specialized setting (beyond the local masjid), ministering to all in a religiously diverse context.’ Its process includes affirmation by the applicant of the Muslim Chaplain Code of Ethics, and a commitment to serve all people regardless of their ethnic, religious backgrounds and moral values. An endorsement is valid for a specific period of time, for a specific institution. It may be withdrawn for non-conformity with the chaplaincy standards and for ethical breach or felonious activity (Chaplaincy Services n.d.).

The MEC, established in 2010 following discussion over many years among Muslim prison chaplains on the need for a support group, aims to provide a ‘structure and process for the official endorsement and support’ of Muslim chaplains ‘based on Islamic and pastoral principles.’ It also seeks to ‘establish standards’ for such endorsement in order to ‘develop consistency and integrity’ in the field of Islamic Chaplaincy (Muslim Endorsement Council of CT n.d.).

Both ISNA and MEC seek to provide support for Muslim chaplains in public institutions. As such, they also respond primarily to governmental demands, particularly in correctional and military institutions, for a religiously authoritative and accountable governing body, on the model of Christian and Jewish denominational structures. ISNA and MEC are examples of two organizations that have registered with the federal and state governments, though neither is an official Muslim denominational structure. Healthcare and campus chaplains may or may not seek such endorsement, depending on the employer’s demands. Endorsement is a domain in which external demands may reshape organizational and authority structures within minority
Seeking Muslim healthcare chaplains

Surveying job advertisements for Muslim chaplaincy gives some insight into the kinds of roles chaplains are expected to fulfil, who is being sought, and what kinds of gatekeeping takes place. In British institutions, the nomenclature for Muslim chaplaincy positions has varied considerably, including such terms as imam, visiting minister, Muslim chaplain, Muslim lay visitor, Muslim advisor, religious advisor, and spiritual advisor (Gilliat-Ray and Ali 2016). The titles of the job advertisement, educational and other qualifications, and job responsibilities construct an ideal candidate with gendered and racial implications. We searched all US chaplaincy job postings online that mentioned Islam(ic), Muslim, and imam from June through December 2018. Muslim healthcare chaplaincy postings differ from other Muslim chaplaincy positions (prisons, university), with a clearer minimum bar for consideration: a seminary or similar graduate degree, and the completion of at least some CPE. Beyond this, there is great variation and ambiguity in what constitutes the ideal candidate.

One Muslim healthcare chaplaincy job posting in the Boston area had a generic boilerplate listing not specific to Muslims except in the job title: Chaplain/Imam. This conflation of terms suggests an unfortunate assumption that the terms chaplain and imam in a Muslim context are synonymous and interchangeable. Another possibility is that either a chaplain or an imam would be suitable and qualified for the position, though it is unclear whether the qualifications would be altered accordingly.

Inclusion of ‘imam,’ however, signals gendered male authority. This implicit bias toward traditional forms of male leadership appears in other job ads as well; a position in New York at a veteran’s medical centre includes providing Friday prayers as one of the job functions. Likewise, another ad for a position in a Chicago area hospital lists leading Friday prayer as a main function. Such a requirement signals that women need not apply. For this same position, another requirement was that the applicant be ‘in good standing with the Muslim community.’ It is unclear which Muslim community has the singular authority to approve a potential candidate, though often such generalities refer to orthodox Sunni mosque organizations. None of the job ads required specific sectarian affiliation, though one made explicit that a Muslim chaplain would serve Muslims of ‘all denominations and cultures.’ In addition to the conflation of chaplain with imam, and Muslim with Sunni male, we also note in at least one instance, the elision of Muslim with Arab. For a Boston hospital chaplaincy position, candidates must be fluent in Arabic conversation and Qur’anic recitation, in order to serve not only the hospital’s Muslim population, but also Arabic speakers from other religious traditions as well.

Women’s religious leadership

Spiritual care has provided a form of religious leadership for women in the Muslim community. With imam positions for worship leadership and preaching restricted to males, ‘chaplaincy is particularly attractive to women looking for a professional avenue within which to pursue Muslim communal leadership and Islamic learning’ (Stark 2015; cf. Gilliat-Ray and Ali 2016). In our recent US survey, women made up approximately a third of chaplains across all sectors. For many, this is also a reassertion or recovery of the tradition of women’s leadership in Muslim communities (Mattson 2005). A Muslim chaplain’s early study of Muslim patients
in California indicated that 64 per cent of Muslim patients did not consider the gender of their spiritual provider important (Abu-Shamsieh 2012: 64).

Ingrid Mattson, former president of the ISNA and founder of Hartford Seminary’s Islamic Chaplaincy Program, has noted that, with no ordination in the Islamic tradition and no council or hierarchy to confer legitimacy, ‘scholarly authority is always relational’ (Yuskaev and Stark 2014: 53). Women training in chaplaincy programmes and serving in healthcare settings relate to patients, staff, and communities, drawing authority, not only from theological training, but also from pastoral skills, cultural awareness, and healthcare system knowledge.

Muslim women chaplains, many easily identified as Muslim by a head scarf (hijab), are often fearful of being stereotyped on the hospital floor. One chaplain intern described how she modified her hijab style so that ‘people did not immediately associate myself as being Muslim. Just to give me the opportunity to forge that conversation with the patients, so it didn’t become a barrier.’ She was pleasantly surprised to find out that being Muslim did not matter to most patients. Being visibly Muslim may even help to challenge stereotypes. A hijab-wearing chaplain was initially rejected by an older Caucasian female patient, who said, ‘Oh, well you don’t believe what I believe.’ The chaplain replied, ‘Oh, really? . . . I would love to hear what you believe.’ Her response startled the patient, and she requested many more visits with this chaplain (Abdul Majid et al. 2019).

Support for women chaplains can come from their male counterparts. One male chaplain refuses to use the titles imam or shaykh “because that is [a] chauvinist approach to chaplaincy. It means all my colleagues who are females will be automatically discredited. And that is unethical and unprofessional. I’m a chaplain and that’s my title. That’s what’s on my badge.’

Muslim women healthcare chaplains provide additional resources to their local Muslim communities, especially in advocating for attention to stigmatized issues like mental illness or domestic abuse. One US chaplain created a confidential referral service in her mosque for patients released from hospital or those suffering from anxiety, depression, or trauma. Many local mosques have begun referring to women chaplains and inviting them to speak at mosque sponsored events. Some chaplains envision serving in official mosque leadership positions; just as there are imams and youth directors, women provide most of the volunteer labour; and women congregants need a female leader with whom to speak.

**Chaplains as public faces of Islam**

Muslim chaplains employed in private or public healthcare facilities in Western countries have a significant role to play in representing a public face of Islam, particularly in societies where Muslim identity is marginalized or demonized. African-American Muslim pioneers have provided much of the foundation for the professional reflection on chaplaincy, and a diverse group of younger chaplains are building a practical theology and ethic of care to sustain the profession. Muslim healthcare chaplaincy represents both the recent professionalization of a communal obligation for Muslim communities to care for the sick and a revival of a pastoral role distinct from the preacher, prayer leader, and interpreter of shari’ah obligations. Muslim chaplains in Western countries, many of whom were trained and mentored in Protestant seminaries, are actively translating, adapting, and exporting models of CPE to Muslim majority countries. In the process, they are encouraging the development of theological and pastoral training for imams as well as the religious leadership of women in Muslim communities.

In post-9/11 North America and post-7/7 UK, in the midst of a global ‘war on terror,’ and with the rise of Islamophobic rhetoric from politicians in most Western countries, Muslim patients frequently face unacknowledged bias from healthcare workers. Many
are also immigrants and refugees with cultural and linguistic barriers to care and fears that accessing public support services may compromise their immigration status. Muslim healthcare chaplains provide spiritual care in the midst of human suffering as an expression of their own faith and solidarity with others. With unique access to interfaith training, demonstrating cultural humility, and drawing on the resources of their own adaptation to cultural and religious norms in Western countries, they enable both enculturation and integration of Muslim patients and staff into local communities or forms of practice, as well as demystifying Islamic traditions and Muslim practices for their non-Muslim counterparts and the public. There is a burgeoning interest among Muslim chaplains to develop practical theologies of care through the contextualization of Islamic tradition in public institutions.

Notes

1 In 2018, the first two authors and chaplain Shareda Hosein conducted the first national educational and needs assessment survey of US-based Muslim chaplains; a report was published on the Association of Muslim Chaplains website (Laird and Abdul Majid 2019). Qualitative interviews with current and former Muslim healthcare chaplains for the ongoing study were conducted anonymously and are reported using pseudonyms, consistent with standard anthropological practice to protect confidentiality. The funding for the qualitative interview study was provided by a grant from the Association of Professional Chaplains—Transforming Chaplaincy project (Abdul Majid et al. 2019).

2 The Muslim Endorsement Council was renamed in 2020: “to reflect the refocused effort to advance endorsement on a national level, MEC changed its name to the Muslim Endorsement Council Inc (MEC) and expanded its board composition to cover not just Connecticut but the entire United States.” https://muslimendorsementcouncil.org/about-mec/#FormationofMEC (accessed 7 May 2021).

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