J Relig Health
DOI 10.1007/s10943-010-9428-6

ORIGINAL PAPER

The Role of Imams in American Muslim Health: Perspectives of Muslim Community Leaders in Southeast Michigan

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Abstract American Muslims are a diverse and growing population, numbering nearly 200,000 in Southeast Michigan. Little empirical work exists on the influence of Islam upon the healthcare behaviors of American Muslims, and there is to date limited research on the roles that imams, Muslim religious leaders, play in the health of this community. Utilizing a community-based participatory research (CBPR) model through collaboration with four key community organizations, we conducted semi-structured interviews with 12 community leaders and explored their perceptions about the roles imams play in community health. Respondents identified four central roles for imams in healthcare: (1) encouraging healthy behaviors through scripture-based messages in sermons; (2) performing religious rituals around life events and illnesses; (3) advocating for Muslim patients and delivering cultural sensitivity training in hospitals; and (4) assisting in healthcare decisions for Muslims. Our analysis also suggests several challenges for imams stemming from medical uncertainty and ethical conflicts. Imams play key roles in framing concepts of health and disease and encouraging healthy lifestyles outside of the healthcare system, as well as advocating for Muslim patient needs and aiding in healthcare decisions within the hospital. Healthcare partnerships with these religious leaders and their institutions may be an important means to enhance the health of American Muslims.

Keywords Muslim chaplain · Mosques · Minority health · Islam · Spirituality

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Published online: 19 November 2010

Introduction

Religious values and beliefs influence healthcare behaviors in multiple ways. As religious values and beliefs are intricately linked to cultural norms and practices, they shape patients' notions of health and illness, influence expectations of the doctor-patient relationship as well as adherence to doctors' recommendations, guide medical-decision making, and influence health outcomes (Fukuhara et al. 2003; Geertz 1983; Johnson et al. 1999; Nehra and Kulaksizoglu 2002; Nielsen et al. 2003). Religion and spirituality also have direct effects upon mental and physical health through influencing coping strategies, health behaviors, and healthcare-seeking attitudes (Koenig 2008, 2009; Larson et al. 2002). The importance of religion and spirituality in supporting individuals and families within the hospital is further attested to by the presence of professional chaplaincy organizations within healthcare (Association of Professional Chaplains et al. 2001; Ford and Tartaglia 2006; VandeCreek and Burton 2001). While these chaplaincy and pastoral care programs largely grew out of Judeo-Christian healing traditions, they have begun to incorporate and accommodate other faith traditions to serve an increasingly diverse population.

Islam is one faith tradition of growing importance in the United States. Estimates of the American Muslim population vary widely, and it is a subject of some controversy. Inaccuracies in naming algorithm and country-of-origin proxies for Islamic affiliation, decreased formal self-identification with Islam in the post-9/11 world, and political motivations are among some of the factors that influence population estimates. The average estimate is 5.4 million, while recent sources cite a figure of around 7 million. The major ethnic groups within Muslim Americans are indigenous African Americans, South Asians, and Arabs (American Muslims: Population Statistics 2005; Ba-Yunus 1997; Muslims American Demographic Facts 2010; Obama 2009; Smith 2002; The World Almanac and Book of Facts 2001 2001). Although American Muslims come from diverse ethnic backgrounds, their religion serves as a unifying dimension of their culture. Many aspects of health care may be informed by the practice of Islam—from conceptions of disease and cure to the interactions of Muslim patients with the healthcare system.

The medical literature portrays Muslim practices as both barriers to, and enablers of, good health (Laird et al. 2007). For example, Ramadan fasting and performing Hajj, the pilgrimage to Mecca, are seen to pose health risks, while other Muslim practices such as avoiding alcoholic beverages and practicing abstinence outside of marriage may provide health benefits (Ahmad 2004). Similarly, Islamic ethics on the one hand is seen to present challenges in healthcare delivery, for example through a preference for same-sex providers, yet at the same time can aid providers in promoting health through the support of genetic testing and family planning (Athar et al. 2005; Hutchinson and Baqi-Aziz 1994). Much of what is accessible to practicing clinicians through Medline about the influence of Islamic beliefs and/or practices on American Muslim health behaviors is largely noted through expert commentaries and opinion pieces, as there exist relatively few empirical studies on this topic (Hammoud et al. 2005; Johnson et al. 1999; Laird et al. 2007; Matin and LeBaron 2004; Moazam 2001; Simpson and Carter 2008; Underwood et al. 1999).

However, studying the ways in which the Islamic faith influences American Muslim healthcare behaviors is of import. Different healthcare-seeking behaviors stemming from Islamic concepts about illness and Islamic rulings about permissible therapeutics may contribute to poorer health outcomes in this community (Johnson et al. 1999; Padela 2010; Rajaram and Rashidi 1999). Furthermore, post-9/11 discrimination and abusive behaviors toward Muslims may lead to increased psychological distress and mistrust of the healthcare system, which in turn may have negative consequences for health (Abu-Ras and

Abu-Bader 2008, 2009; Padela and Heisler 2010). Lastly, health care providers may treat Muslims differently than other patients due to stereotypes or face greater clinical uncertainty due to unfamiliarity with their cultural practices and values. Systematic research on these issues has been hampered as most healthcare databases do not capture religious affiliation, thus precluding analyses by religion. Further, using naming algorithms and ethnic and racial affiliations as a proxy for religious identification with Islam has not yet been validated within medical research. In short, there are multiple challenges in assessing and addressing healthcare disparities in the American Muslim population (Laird et al. 2007).

A logical starting point for understanding the influence of Islam upon American Muslim health may be through understanding the roles of religious leaders who serve this faith community. In over 1,200 mosques, imams, Muslim religious leaders, provide a variety of spiritual and non-spiritual services to the American Muslim community (Bagby et al. 2001; Muslims American Demographic Facts 2010). There are different types of imams who have multiple overlapping roles within the Islamic tradition. For example, an imam can be a person who simply leads congregational prayers, someone who serves as a spiritual advisor, or an Islamic legal expert; multiple but not necessarily mutually exclusive types of Imams exist (Kjeilen 2010; Maghnisawi 2007). Furthermore, since Sunni Islam does not have a formalized clergy system by which a central authority interprets the faith and directs spiritual leadership, imams have diverse qualifications and expertise (Boender 1999). Table 1 provides a brief taxonomy of different types of imams. For the purpose of this paper and the American context, we define an imam as the individual who is a prayer leader, chief sermon giver, and spiritual advisor to the congregation of a mosque. As sources of Islamic knowledge, imams interpret for the Muslim community how Islam informs health care provision and behaviors (Freij 2010). They also serve as confidants providing counseling to ill-stricken congregants and as religious adjudicators on ethical challenges around medical care (Ali et al. 2005; Freij 2010). While women may serve functions similar to imams, normative Islamic law does not permit women to lead men in prayer; thus, they are not given the title imam.

The community role of this type of mosque-based imam is analogous to the role of Christian priests or ministers and Jewish rabbis. However, while the medical literature is replete with studies describing partnerships with rabbis and priests to improve Jewish and Christian health, respectively, and chaplaincy programs have effectively incorporated these faith leaders within hospital systems, few imams have been included in such initiatives, and little is known about their multiple roles in American Muslim health (Campbell et al. 2007; Flannelly et al. 2003; Shuper et al. 2000). Research within the United States notes the beneficial role imams may play in promoting mental health through counseling and in facilitating healthcare initiatives; however, a fuller taxonomy of their roles in the American context is lacking (Abu-Ras et al. 2008; Ali et al. 2005; Taylor and Holtrop 2007). In this paper, we seek to address this gap in the medical literature regarding the roles imams play in American Muslim health.

Methods

Setting

Southeast Michigan is home to one of the oldest and largest populations of American Muslims in the United States. Accurate numerical assessment of the population is complicated by several methodological challenges and the lack of recent survey data. Some

Table 1 A brief taxonomy of imams

Type	Description	Comment
Imam = Prayer leader	The most general definition of an imam is a congregational prayer leader	This individual leads prayers at a mosque at specific times formally or informally. The term can also be used for an individual who leads prayer once for a group of people and may not do so on a regular basis
Sermon Giver = Imam and/or *Khateeb*	Gives sermons that are a requisite part of Friday (*Jummah*) prayer services and Holiday services (*Eid*)	This individual often, but not always, has some level of Islamic educational attainment and is asked to give sermons by the mosque leadership,
Spiritual Guide = Imam and/or *Shaykh*	Sought out by Muslims for spiritual guidance around life events, the esoteric sciences related to purifying one's character and belief, and "spiritual cures"	This individual is often referred to as a *Shaykh,* which is also a ubiquitous term in the Islamic tradition. Such an individual is often associated with Sufi paths in the Islamic tradition
Islamic Law Expert = Imam and/or *Shaykh*	Studied Islamic law and ethics extensively through formalized Islamic seminaries and colleges. Specialized in Islamic law and is authorized to issue religious edicts (sing. *Fatwa*, pl. *fatawa*)	The legal theorists of the classical era who promulgated the dominant extant schools of Islamic law (Maliki, Hanafi, Shafi, Hanbali, and Jafari) are all accorded the honorific title imam
Director of Mosque = Imam and/or *Shaykh*	A mosque-based imam who is hired by the mosque administration to serve multiple roles for congregants, including religious ceremonies and prayers	This individual may fulfill some or all of the types of imams listed above

estimate the number of Muslims to be around 200,000 (Hassoun 2005; Michigan 2003; Numan 1992).

Design

We used a community-based participatory design by partnering with four key Muslim and/or Arab community organizations: two Islamic umbrella organizations that represent over 35 Muslim organizations including over 25 mosques, an American Muslim policy institute, and an Arab community health organization. Members from these organizations, along with an interdisciplinary investigative team, formed part of a steering committee that guided all phases of the project, from research question and interview guide development, to participant recruitment, data analysis, and dissemination (Israel et al. 2005). The interdisciplinary investigative team included a Muslim physician researcher with expertise in Islamic law and ethics and experience as a part-time imam and as a volunteer healthcare chaplain, a social worker active in Muslim advocacy organizations, an experienced qualitative researcher who studies the influence of culture upon healthcare encounters, a senior health services researcher, a nurse investigator who has experience working with the Muslim American community, and several individuals with public health qualifications.

Sampling

Representatives from these organizations and steering committee members identified key informants and community stakeholders to be interviewed and outlined interview protocols

and questions. We used a purposive maximum variation sampling method within the potential participant pool to identify community leaders with a wide variety of experiences and views (Patton 1990). Specifically, we attempted to interview both men and women, persons with different positions within the Muslim community (including 2 imams), and persons who represented different ethnicities, races, countries of origin, and theological sects within the identified sample.

Data Collection

Between July and August of 2009, three members of the research team conducted 12 qualitative semi-structured interviews. Interviews lasted 1–1.5 h, were conducted at participants' choice of location, and were gender concordant if requested by participants. Through open-ended questioning, participants were asked about American Muslim health beliefs, health seeking behavior, and health challenges. As the influence and role of imams emerged within our first interviews, we iteratively adapted our interview guide to include probes to specifically inquire about the role of the imams. Given the different experiences shared by the diverse sample, some areas where explored in more depth than others during the interviews. Sample interview questions that elicited a discussion of the imam included: Can you think of ways in which Islamic beliefs may play a positive/negative role for Muslim health? Are there any ways Islamic teachings influence how Muslim Americans seek healthcare, i.e. who they see, when and how? Can you give me concrete examples and stories? Can you share with me how Islamic beliefs or teachings might have played a role when you or someone you know got sick? As participants mentioned the Imam, conversational probes were used to gain a fuller understanding of the Imam's role. Sampling continued until no new themes were emerging on the ways Islam influences health behaviors. This project was approved by the University of Michigan Institutional Review Board.

Data Entry

Interviews were audio recorded and transcribed verbatim by a professional transcriptionist. As respondents sometimes spoke in Arabic and English, Arabic terms were translated into English by a bilingual team member and verified for accuracy by a second bilingual team member. In order to protect confidentiality, in this paper, pseudonyms are substituted for real names, and minimal descriptors are used for participant quotes.

Data Analysis

QSR Nvivo v8 was used to facilitate coding and analysis. Detailed content analysis of the data utilized a framework and team-based approach. Analysts immersed themselves in the data by reading and open-coding the transcripts to develop a preliminary coding scheme. The first four transcripts were double-coded to calibrate the coding scheme and process. Disagreements were resolved by team consensus, and emergent themes were discussed via a constant-comparison method during team meetings. A revised coding scheme was developed and applied to the eight remaining transcripts. Each transcript was assigned an analyst to develop a summary by code and to perform local integration of codes by grouping codes into higher order conceptual themes. These summaries were used in team meetings to perform global integration of themes across the interviews (Weiss 1994).

Below, we weave these findings into a narrative reflecting participants' views on the role of the imam in American Muslim healthcare.

Results

Participant Characteristics

Among the 12 participants, there were 7 men and 5 women. Most were Arab Americans, Sunni Muslims, and held advanced degrees. Our sample included 2 imams, and the participants represent a variety of countries of origin and play various roles in the American Muslim community (Table 2).

Roles of the Imam in American Muslim Healthcare

Four major types of roles for imams in healthcare emerged during the thematic analyses: (1) Encouraging healthy behaviors through scripture-based messages in sermons; (2) Performing religious rituals around life events and illnesses; (3) Advocating for Muslim patients and delivering cultural sensitivity training in hospitals; and (4) Assisting in healthcare decisions for congregants. Participants also identified several areas of cultural conflict and challenges for imams.

Encouraging Healthy Behaviors through Scripture-Based Messages in Sermons

Participants discussed how imams may deliver health-based messages through sermons and lectures. One of the most opportune and widely attended venues is the congregational Friday prayer, *jum'uah*. Held at all mosques, *jum'uah* holds great significance as it is obligatory upon Muslim men and is often a family activity. In areas with large Muslim populations, multiple prayer sessions and multiple sermons may be conducted at a single mosque lending variety among both the message and the messenger. Ibrahim, an imam, illustrates his role in sermon-giving by stating that imams play "a tremendous role … when (they) … remind(s) them (the congregation) (that) … He (God) is the one who cures" (Qu'ran 26:80) and "that is really the role of (an) imam … (to) let (the congregation) know that sickness is a test from Allah". Framing disease as coming from God does not preclude seeking healthcare, another imam explained to us: "the Prophet encourage(d) Muslims to seek (health)care by saying 'the servant of Allah (should) seek care, for Allah will not send any sickness but Allah send(s) out the cure". Participants related that by framing disease and healing as coming from God, imams aid Muslims to cope with illness by helping them to maintain hope in the Divine. The participants also allude to imams' messages around moderation and health promotion. For example, participants mentioned that some of the messages delivered from the pulpit are "to take care of our health … that (the body) … is a trust (from God)" and to be moderate in eating as referenced by the Qur'anic verse "Eat and drink and don't go beyond the limit".

Maryam shares a view that the mosque is central to American Muslim health. She said "we have lectures (at) this mosque … (and) all across the country … health is one of the topics,… so our mosque is an integral part, I think, of keeping us healthy". Notably, another respondent, Ahmad, felt that healthy practices should be encouraged more directly in sermons, stating, "I find fault with the (sermons) … (by them) not directly … relating to the health care of your body and what Islam says about it. And the imam does not …

Table 2 Participants characteristics ($N = 12$)

	N
Age, mean (SD), *y*	44.3(13.6)
<30 years	2
30–55 years	7
>55 years	3
Sex	
Male	7
Female	5
Religious affiliation	
Sunni	8
Shi'ite	1
Prefer not to say	3
Ethnicity	
Arab/Arab American	6
African American/Black	2
South Asian	2
European/White	1
Other	1
Education level	
<Associate degree and/or some college	2
4-year college degree	2
Advanced degree (Masters, Doctorate)	8
Country of origin	
United States	6
Other	6
Africa	1
Europe	1
Middle East	3
South Asia	1
Primary role in American Muslim community	
Imam	2
Leadership role in community health organization	3
Leadership role in community civic organization	1
Community organizer	2
Allied health professional	4

emphasize the importance of getting an annual or semi-annual check". These data illustrate that imams sometimes use health care messages from the Qur'an to guide the health of American Muslims and that some congregants expect to receive, and may desire more, health relevant sermons from imams.

Performing Religious Rituals around Life Events and Illnesses

The participants also provide insight into how imams perform religious rituals around life events and illnesses for American Muslims. These functions can include blessing births,

visiting the sick, and overseeing burial services. When asked about these responsibilities, Ibrahim, an imam said "(Being an) imam entails …. first and foremost, guiding the community … and also visiting a sick person … if somebody dies … either you get involved in the washing of the body or directing (sic) people how to do that and … praying for the deceased person". Thus, imams can serve important ritualistic functions around life and death for American Muslims, and their presence may be requested by Muslim patients in the hospital.

In addition to roles around life events and visiting the sick, participants noted that imams are often requested to make special prayers for sick congregants and/or their relatives. Kareem describes his belief in the power of such prayers in his story about "a brother (that) had bleeding that wouldn't stop from prostate cancer and the imam prayed and it stopped and they (the doctors) don't know why. What can you say? What can the doctor say? What can anybody say?" The participants also shared that some Muslims believe that reciting certain verses of the Qur'an and certain prayers over food can have healing qualities and that they may request imams to read these verses and perform these prayers. Sanna elaborates: "we believe in … shifa (Healing) … so someone like (an imam) who lead(s) prayer on food … and then people who are sick eat that (to restore health)".

Some religious leaders may serve a more direct therapeutic role as counselors and alternative mental healthcare providers. An interesting story with cross-cultural implications was shared with us by Jamila, a nurse in our sample. She relates to us the concern one family had about *jinn* influence causing psychological symptoms: "for one woman that I know—and I think this is not unusual—when she first developed symptoms…their (the family's) initial response was to take her to a shaykh (imam) and see if it was a jinn possession and to try (to) … cure her". In the Islamic tradition, *jinn* are held to be largely invisible beings created by God who, akin to human beings can do both good and evil, and may at times interact with and exert influence over humans.

Advocating for Muslim Patients and Delivering Cultural Sensitivity Training in Hospitals

Per these participants, imams often can take on larger roles within the hospital and healthcare system as part of a religious duty to visit the sick. Muhammad, a healthcare worker, described the perceived beliefs about the role of imams in the hospital. He told us, "Maybe a sheikh (imam) comes from the masjid (mosque) (to educate healthcare workers about) when you come across these Muslims, this is the kind of beliefs … that you might encounter". The goal of such activity is to provide staff with a cultural knowledge base and tools that can help healthcare professionals understand and facilitate care that is attuned to Muslim beliefs. As one of our imams notes, "many of the staff … have no idea what Muslims believe … once they know that, they are more sensitive and they know how to approach them (Muslims) … and how to respect them and not offend them". Our respondents noted that not many imams have formal hospital appointments, and thus "many patients are surprised when they know that (t)here is (an) imam on the staff to visit them, and to take care of them, and make sure that their traditional beliefs are respected". This illustrates the role imams can play as cultural brokers to benefit both Muslim patients and staff.

Assisting in Healthcare Decisions for Congregants

The project respondents also provided examples on how imams play an integral role in healthcare decision making for Muslims both within hospital and mosque settings. For

example, Taha, a nurse, describes his observations about the role imams have taken at his hospital in family meetings. He explains that "we have (had) to invite local imams to sit in on family meetings with physicians to help the family make the decision with, as far as considering the faith and the rulings because … they just had the medical advice so they (the family) wanted religious advice". The role in assisting in healthcare decisions for American Muslims was also illustrated by Isaac, an imam. He explains that the role for imams is to "try to close the gap between physicians and family" and "inform them (the healthcare staff and patient family) what can be done and what cannot be done according to religion". This illustrates the role imams can play as interpreters and brokers in complex healthcare-decision making.

From these community leaders, we also learned about the roles imams can play for individuals in the health care professions. One nurse participant, Aaliyah, discussed an experience she had early in her career when she felt conflicted about whether she could perform urinary catheterizations on men. She consulted an imam to ascertain whether it was religiously permissible to perform urinary catheterizations on male patients while upholding the Islamic rules of modesty. She was told that "this is permissible", allowing her an exemption from the Islamic rulings prohibiting such intimate interactions in social settings. Thus, imams can serve as religious consults, helping both patients and healthcare workers to make decisions in-line with Islamic law and ethics.

Challenges for Imams

Our community leaders also described several challenges faced by imams. These tensions may arise for various reasons, including but not limited to divergent values held by imams and healthcare practitioners, a lack of medical knowledge on the part of some imams, clinical uncertainty, and the lack of access to, or availability of, imams. For example, Isaac, an imam, relates that his assistance is often requested by the healthcare team with an implicit directive "to encourage the patient to do … (the procedure) if the doctor says you have to do it" and "to sometimes convince" patients through religion-based argumentation. Implicit in this role is that physician recommendations or medical interventions in general are always beneficial and that imams should be able to convince patients to accept these interventions. However, some respondents felt uneasy with the perceived co-opting of the Islamic faith in such a manner. For example Amin, a doctor, states "I think using religious venues and sharing common values is okay. So going to the masajid [mosques] and encouraging women to get their mammograms and … men to get their prostate exams, for people to get colonoscopies—that's totally cool … when you go to the next step and you say that Allah wants you to get a colonoscopy … I get nervous … that's not my understanding of my religion". Hence, there seems to be an ethical line between coercing Muslims to seek healthcare using religiously laden messages and general health promotion activities at the mosque.

Clinical uncertainty can be problematic as imams attempt to apply guidance from Islamic ethics and Islamic law to inform decision making. For example, our informants shared some of their experiences in trying to ascertain the preferred Islamic course of action. Ibrahim, an imam, says that he has been asked to advise on the Islamically valid course of action in numerous medical cases, but felt the medical uncertainty made proper assessment difficult. Ibrahim explains, "Let me give you an example … They (the doctors) said (about an in utero child) the heart is on the right (side) and he has brain damage … he won't make it. He's going to die and (if) … born … he's going to suffer throughout life. And they (the family) call me to ask "What should we do?" I say to give him a little bit

of time…maybe, something will happen …. Well, after one and a half months they (the doctors) said it (the child) is fine … It's a miracle. So that's why I hesitated (the uncertainty)".

Participants outlined some potential risks due to the imams' limited medical knowledge. For example, Nadia, a nurse, feels that imams should have more medical knowledge to enhance their advice instead of just advising prayer. She states "…often times I've heard our imams. say, "Well, you just have to pray some more and … Allah (God) will help you". Well … clinically that's true and not true". Amin, a physician, draws attention to the need for imams to recognize pathologic behaviors. He shares, "I remember … a patient that … had obsessive compulsive disorder…He used to make wudu (Islamic ritual cleansing) 35 times before he could pray … (he) went to the imam (who said) Let him make wudu as many times as he wants … But clearly he (was) dysfunctional". Such examples from our participants illustrate the need for educational efforts to help imams increase their medical knowledge and understand healthcare and the healthcare system.

Our respondents point out that even when the presence of an imam may be beneficial and is requested, accessibility is a challenge. Aaliyah, a nurse, tells us that in her experience "*often* times when you call on these religious leaders, they're unavailable … That's a huge problem … (thus some) … Americans say … Religious (sic) drives everything for you (Muslims) … then … where are your leaders to come and support you at this time?" This highlights the need not only for hospitals to accept and support imams among the ranks of religious leaders to facilitate best quality care to Muslim patients, but also for the Muslim community to support imams in being accessible to health care institutions.

Discussion

This study adds to the growing body of literature seeking to explore and document some of the roles imams can and do play in the healthcare of American Muslims. A qualitative community-based participatory research methodology enabled us to give voice to this under-researched population through partnerships with some of the major religious and health organizations that serve this community. Further, setting this work in Southeast Michigan allowed us to probe the views of Muslim Americans across racial and theological divides lending some strength to our findings. The Muslim community leaders in our sample emphasize that imams play important roles in American Muslim health both outside of, and inside, the healthcare system. Imams utilize sermons to shape an Islamic framework by which American Muslims understand health and disease, thus motivating healthcare behaviors. Imams counsel congregants on health issues, help them to make medical decisions attuned to Islamic law, and may function as alternative/complementary healthcare practitioners providing "spiritual cures". Within the healthcare system, imams play important roles somewhat overlapping those of healthcare chaplains. They visit sick Muslim patients, provide ethical consults for both staff and patients, aid in patient provider–family discussions about healthcare, and serve as religious "translators" and cultural brokers (DeVries et al. 2008). Moreover, imams may facilitate cultural competency efforts for the healthcare system. While imams are exclusively men, both male and female respondents corroborated the important roles played by imams.

These data reinforce previous international findings on how partnerships with imams, and thereby mosques, can be a venue through which community health may be enhanced, trust established, and healthcare disparities reduced. For example, education of imams about tuberculosis resulted in mosque sermons about the topic and increased detection and

treatment in Bangladesh (Rifat et al. 2008). In Afghanistan, imams used Qur'anic verses to promote reproductive planning in order to reduce maternal death rates, and in Britain, the British Heart Foundation engages imams to deliver health awareness-based sermons during Ramadan, the Muslim month of fasting (Mason 2010; Zaidi 2006). Furthermore, mosque-based lectures series have helped to advance health in Austria where mosque lectures have increased community knowledge about cardiovascular disease risk factors (Bader et al. 2006). A similar approach has recently been taken by USAID's Bureau for Global Health where Muslim imams are mobilized to be "champions" of reproductive health and family planning in multiple Muslim-majority nations (Freij 2010).

Our data also suggest that imams play a significant role in American Muslim medical-decision making. Surprisingly, few studies have examined the imam's importance in Muslim medical-decision making (Ahmad 2004; Ali et al. 2005; Kendall-Raynor 2007). In a British study of decision making about prenatal testing for sickle cell disease and thalassemia, Muslim respondents did not feel that imams played a significant role (Ahmad 2004). Yet, our respondents held the opposite view. This may be due to the sampling of different populations, as the British study does not note the inclusion of religious organizations, and their focus groups discussed a specific disease entity, while our sample may have been more inclusive and general. Further studies to delineate the circumstances and nature of imam involvement in medical-decision making are warranted.

These data also illustrate that while health care institutions and providers partnering with imams and mosques have the potential for much good, there is also a potential for ethical conflict. Some argue that "co-opting the assistance of religious leaders" for healthcare purposes is ethically sound (Zaidi 2006). However, the imams in our sample felt uneasy about making medical decisions for patients given the uncertainties of medical science and expressed discomfort with being asked to convince patients to pursue physician recommendations through religion-based argumentation. Additionally, normative healthcare values may be at odds with Islamic values under certain circumstance. Some providers may see ritual fasting as harmful to the body, or Islamic non-acceptance of porcine-based products as zealousness. Yet, these practices can be essential to maintain one's faith identity and are of primary importance to many Muslims. Some of these ethical conflicts may also stem from imams' lack of familiarity with the healthcare system and medicine in general. As there are few imams with formal staff positions within hospitals and hospital boards even within this large Muslim community, perhaps increased involvement would allow for the resolution of some conflicts. Reasons for the sparse presence of imams in formal chaplain roles may be multiple from lack of time and unfamiliarity with chaplaincy roles on the part of imams to financial limitations or difficulty in ascertaining "imam" credentials on the part of hospitals. Nonetheless, it is necessary to delineate more thoroughly barriers to imam involvement in the healthcare system, to explore the types of ethical challenges imams face, and to develop a transcultural ethical framework through which religious beliefs may be used as a motivation for healthcare behavior change.

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. Imams come from varied backgrounds and have various responsibilities and roles in Muslim communities. 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 (Abu-Ras and Laird 2010). 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 (Abu-Ras and Laird 2010; Dudhwala 2010). 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 (Abu-Ras and Laird 2010; Hamza 2007). 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 (Dudhwala 2008; The Fairfax Institute 2006; Islamic Chaplaincy Program 2010). Given that the title Imam carries different connotations (Table 1) and imams have varied qualifications, healthcare systems and imams may face significant "cultural gaps" to being hospital chaplains. As such, a clearer definition of the core competences necessary to become a Muslim chaplain and increased partnership between imams and chaplaincy programs may be fruitful in meeting the needs of Muslim patients in the hospital.

While this work illustrates a spectrum of roles for imams in American Muslim healthcare, it has some clear limitations. While our data legitimately represent the voices of key informants, they are leaders' voices from one community. Given that our participants were chosen by a community steering committee comprised of different types of organizations within a large and well-established American Muslim community, we believe that their views offer invaluable insight into the American Muslim community at-large. However, there may be additional issues that our interviews may not have captured, particularly in communities with less resources. Thus, sampling frames outside of a community steering board and from different American Muslim communities may identify different health roles for imams. Further, our respondents are a small pool selected for being leaders in the community; as such, it is possible that additional interviewing including persons from the 'lay' community would find additional roles or attach a different significance to the roles we have identified.

These findings suggest the need for both empirical and normative research. Future work should focus on gaining views from multiple communities and a larger cross-section of individuals to gauge the depth and generalizability of our findings. While these partnerships promote health, one wonders to what extent does the content of imams' messages influence Muslim health care behaviors? Does framing disease as a test from God influence congregants to delay seeking health care or simply provide a positive coping mechanism with illness? Are imams seen as alternative healers or supplemental resources for health? This introduces additional lines of future work about the impact of imams on the behaviors of congregants and others who receive the message.

Conclusion

This descriptive study demonstrates that imams serve the American Muslim community in several health-related roles. The contexts and content of their advice, the ethical challenges

they face in their roles, and the barriers to involving them within the healthcare system all deserve further inquiry. Still, our study findings have several important implications. Within the healthcare system, healthcare institutions can reach out to American Muslims by initiating religiously and culturally sensitive healthcare awareness campaigns through partnerships with mosques in the American Muslim community. Hospitals may be able to enhance cultural competency training by engaging imams as cultural brokers/facilitators and as volunteers or paid chaplains. Further, we advocate for greater flexibility in hospital protocols around who can offer chaplaincy and spiritual care services, since Muslims as a group and Islam as a discipline of study are both underrepresented in formal chaplaincy training programs. Further, a delineation of core competencies for Muslim chaplains in terms of Islamic law and ethics standpoint remains wanting, and imams may be able to fill this gap. Within the Muslim community, imams should take advantage of their leadership roles and utilize their sermons and educational venues to encourage American Muslims to care for their health through both prevention and intervention methods. Institutional support is needed for imams to be available for Muslim patients in hospitals, especially during times of death and burial. Mosque congregations should encourage and support imams in this endeavor through financial and human resources. In summary, imams play key roles in American Muslim community health, and partnerships with them may be a means to improve community health and deliver culturally sensitive, high quality care to American Muslims within the healthcare system.

Acknowledgments This study was funded through the Robert Wood Johnson Foundation Clinical Scholars Program and by the Institute for Social Policy & Understanding. It was presented in part at the 2009 RWJF Clinical Scholars National Meeting. Dr. Fetters' participation was made possible through the generous support of the Jitsukoukai Medical Foundation and Qatar National Research Foundation grant # NPRP 08-530-3-116. We thank our respondents for sharing their time and insight with us, as well as the community partners and steering committee members for their invaluable insight, recruitment assistance, and support: Muzammil Ahmed MD, Hamada Hamid DO MPH from the Institute for Social Policy & Understanding, Najah Bazzy RN from the Islamic Center of America, Adnan Hammad PhD from the Arab Community Center for Economic & Social Services, Mouhib Ayyas MD from the Islamic Shura Council of Michigan, and Ghalib Begg from the Council of Islamic Organizations of Michigan. We also thank Amanda Salih MPH for aiding in interviews, coding manuscripts, and data analysis, and Jane Forman ScD, MHS for interview guide development and qualitative interview training.

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