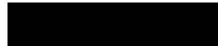
Discrimination Towards American Muslims in Healthcare



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Abstract

This paper discusses discrimination towards American Muslims in the modernized healthcare system. Since 9/11, American Muslims have experienced unprecedented levels of discrimination in mainstream society. As a result, many non-Muslim individuals hesitate to engage with the American Muslim population, making them unaware of Islamic religious beliefs. The effects of this unfamiliarity have trickled down into the healthcare system. Shortcomings in healthcare accommodations and cultural competency have instigated healthcare disparities for American Muslims in the United States. Although many American Muslims use their religion as a guide for the healing process, healthcare providers are often unwilling to adapt to the needs of their American Muslim patients. These discrepancies in healthcare accommodations engender discrimination and mistrust, resulting in decreased qualities of care and health outcomes for American Muslim communities. To mitigate these healthcare disparities, the current system of cultural competency training must be restructured and strictly implemented across all medical institutions and teaching hospitals in the United States.

Minorities often face discrimination in their interactions with American healthcare because of the system's inability to account for cultural sensitivity during patient care. When discussing healthcare disparities relating to minority groups, the American Muslim population remains of particular interest due to its relative size and shared belief system. Despite differences in ethnic backgrounds, many American Muslims use Islamic doctrine as a foundation for medical preferences and decision-making. Consequently, American Muslims often share similar ideologies about how medical professionals should interact with them in patient-physician relationships (Padela, Gunter, Killawi, and Heisler, 2012).

Although religious influences may play a vital role in treating American Muslim patients, providers and hospitals often fail to adapt themselves to fit this population's needs. Many American Muslims believe that the modern healthcare system fails to accept and accommodate services based on their religious beliefs (Padela et al., 2012). Additionally, many members of this population have been ridiculed for expressing their religious beliefs in the clinical setting, thus indicating negative provider attitudes (Padela et al., 2012). With all of this in mind, it becomes increasingly important to evaluate why American Muslims face healthcare disparities and how those disparities can be alleviated going into the future. American Muslims experience poor qualities of care, and subsequently, poor health outcomes, due to inadequate religious healthcare accommodations and discrepancies in cultural competency. To mitigate these healthcare disparities, the current system of cultural competency training must be restructured and strictly implemented across all medical institutions and teaching hospitals in the United States.

Before analyzing discrimination against American Muslims in the healthcare setting, it is important to understand the historical context of Islamophobia in America. Islamophobia can be defined as feelings of hatred and hostility towards the Islamic faith and its followers, Muslims.

The Western world and Islam have been at odds for many centuries, but this conflict became more defined in the United States following the terrorist attacks of 9/11 (Wagner and Leibold, 2010). In fact, according to Lajevardi (2017), American Muslims were more likely to experience discrimination based on ethnic background rather than religious identity prior to 9/11. Following 9/11, the media played a large role in portraying American Muslims as perpetrators of crime and violence under the common name of Islam. Rather than reporting the positive contributions of Muslims to American society, the media has focused on domestic and international terrorist attacks carried out by Islamic extremists, thereby giving uninformed Americans further justification for their hatred (Wagner and Leibold, 2010). Typically, Non-Muslim individuals lack interpersonal contact with American Muslims in their daily lives. This causes them to reject the Islamic faith through indirect misperceptions generated by the media (Wagner and Leibold, 2010).

Recently, Islamophobia has become more extensive due to political rhetoric from the Republican party, and more specifically, President Trump. Abdelkader (2016) reported an increase in anti-Muslim attacks before and during the 2016 presidential election cycle. This development further supports the idea that nationalist sentiments have continued to grow alongside sociopolitical propaganda. The growth of Islamophobia can also be attributed to the perspectives of government officials as a whole. Lajevardi (2017) found that state legislators were less responsive to American Muslims in comparison to white Americans, while also citing that legislators often exhibited anti-Muslim sentiments through policy decisions. These trends in Islamophobia over the past two decades provide convincing evidence to suggest that American Muslims are faced with unwarranted prejudice in the broader context of modern-day American society.

Discrimination towards American Muslims is not limited to the scope of sociopolitical sentiments. This group also encounters various forms of discrimination in the modernized healthcare system due to shortcomings in healthcare accommodations. One of the most important aspects of healthcare delivery is the ability to accommodate care to the needs of all patients, regardless of their religious and/or cultural backgrounds. Healthcare accommodations help patients comfortably adapt to the clinical environment, thereby advancing patient-centered care. Although accommodations can increase concordance in patient-physician relationships, American Muslims strongly believe that they do not receive proper religious accommodations under the current healthcare system (Padela et al., 2012). For instance, Padela et al. (2012) and Martin (2015) found that many American Muslim patients recount the absence of halal food, gender concordant physician-patient relationships, and neutral prayer spaces in various clinical settings. In many of the patients' personal statements, they also claim to have experienced backlash and criticism from their providers when asking for religious accommodations. Gender, diet, and prayer play a large role in Islam and its interpretation of the healing process, so failure to accommodate for these factors leads to lower levels of patient satisfaction (Attum, Waheed, and Shamoon, 2019; Martin, 2015). During patient care, social aspects of health play a large role in treating the patient's overall well-being. When the healthcare system ignores services that could potentially ease the worries of their American Muslim patients, they are forsaking the objective of treating the person rather than the disease. As a result of these systematic issues, American Muslim patients experience decreased qualities of care and unsatisfactory patient-physician interactions (Padela et al., 2012).

Leininger's theory of culture care (2002) states that when providers fail to respect the patient's beliefs, healthcare interactions become problematic and less desirable. When American

Muslims expect discrimination in the clinical setting, they are more likely to alter their health-seeking behaviors because they do not want to burden themselves or their providers. In other words, American Muslim patients allow their medical problems to persist because they do not want to experience the negative attitudes that come with interactions in the healthcare system. These low health-seeking behaviors ultimately lead to decreased health outcomes for American Muslims because they allow their conditions to linger for longer periods of time before visiting medical professionals (Padela et al., 2012).

Systematic changes to the healthcare system can address the negative effects of discrimination that result from provider biases. Proper cultural competency training serves as the most practical means of reducing the problems related to healthcare disparities for American Muslim communities. Cultural competency can be described as a set of provider attitudes that promote respect towards a patient's sociocultural values. Numerous studies and reviews have shown that cultural competency is the best method of reducing bias, increasing physician-patient communication, and elevating overall qualities of care (Beach et al., 2005; Betancourt et al., 2003; Stone and Moskowitz, 2011).

Although cultural competency training is the most practical means of mitigating healthcare disparities for American Muslims, the current standards and systems of training have some inherent problems. In 2004, the Liaison Committee on Medical Education (LCME) created a standard of cultural competency training for medical schools across the nation. Within the last decade, many medical schools have been making an active effort to incorporate cultural competency training into their curriculum (Jernigan, Hearod, Tran, Norris, and Buchwald, 2016). However, this active effort has not been enough. Many medical schools require loosely defined cultural competency training, which results in a physician workforce that is inconsistently trained

to deal with the demands of an increasingly diverse American population (Sorrenson, Norredam, Dogra, Essink-Bot, Suurmond, Krasnik, 2017). Some medical schools don't require cultural competency training at all. Jernigan et al. (2016) found that cultural competency training was only required for 67% of the medical schools in their sample. Given these circumstances, medical schools should incorporate cultural competency classes into their curriculum as a strict graduation requirement. In essence, this would create a more rigid system of training that all medical schools would have to follow. If previous evidence and case studies suggest that cultural competency is effective in the long run, all medical schools should be required to provide proper training. Stricter requirements for medical school graduation will ensure that physicians are better trained in cultural sensitivity.

After implementing stricter requirements across all educational institutions, the next step would be to account for variations in cultural competency training. Currently, the degree of sensitivity surrounding cultural competency can be interpreted in numerous ways (Betancourt et al., 2003). Varying interpretations of the term "cultural competency" have created different standards of competency training across several medical schools. As a result, physicians leave medical schools with different levels of training based on what their institutions think is important for them to know (Beach et al., 2005). To solve this problem, the LCME must revise their standard of cultural competency training and make sure that all medical schools follow the same requirements. In their revisions of a set standard, the LCME should create a set of trainings/rules/books that all medical schools must adopt. At the same time, certain aspects of training, such as broader patient population knowledge, could be left up to each medical school. This approach would ensure that all physicians gets a basic level of training, while also providing some level of autonomy to medical schools in terms of deciding what they want to teach. The

LCME could then create review boards for each medical school to ensure that the proper guidelines are being followed.

Lastly, cultural competency training must extend itself past medical schools and into clinical education. Residency programs should incorporate cross-cultural training into clinical practice as a means of practically applying previous teachings from medical school. The majority of competency training occurs in the preclinical phase of medical education, which indicates that providers are not encouraged to continue their practice of cultural competency in the clinical setting. Hospitals should work with physicians in teaching positions to create training that actively reinforces practical cultural competency training in clinical education. This could be as simple as having teaching faculty evaluate a resident's interaction with a patient in a culturally sensitive case (Jernigan et al., 2016; Kripalani, Bussey-Jones, Katz, Genao, 2006). Overall, these interventions would produce a culturally competent body of physicians across the United States. In turn, American Muslims may potentially experience less discrimination in clinical settings.

American Muslims experience discrimination in the healthcare system because their beliefs are not fully accepted by the medical community. As a result, American Muslims struggle to communicate their preferences, which leads to barriers in providing patient-centered and culturally sensitive care. To reduce the effects of biases and discrimination, cultural competency training needs to be restructured and properly implemented for the larger purpose of better serving all minorities, including American Muslims.

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