

# RELIGIOUS ACCOMMODATION FOR MUSLIM WORKERS AND PATIENTS IN HEALTHCARE

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**Abstract:** As the followers of a comprehensive religion that regulates all spheres of human life, it is common for practising Muslims to require certain religious accommodations at their workplaces or during any clinical encounter. This paper aims to identify the factors that facilitate the provision of religious accommodation in healthcare for both Muslim healthcare workers and patients, by specifically examining three issues: provision of halal food, prayer facilities, and Muslim-friendly dress codes. In this qualitative study, document analysis and secondary data analysis are conducted. Thematic analysis is conducted to identify the factors which influence religious accommodation in healthcare. The findings illustrate that the prospect of accommodating religious needs does not merely depend on the religion of the majority of the population, but on various factors, such as the country or the state where the healthcare institution is situated, the healthcare institution itself, the sections or departments within the healthcare institution, and the personnel who deal directly with healthcare personnel or patients requiring the religious accommodation. In addition, awareness, attitudes, rules and standards, and availability of resources also influence the provision of religious accommodation. The results suggest that individuals seeking religious accommodation at any institution ought to play a more active role in obtaining accommodation at various levels. Besides that, religious accommodation can be enhanced by improving knowledge, attitude, standards, regulations, and availability of resources in healthcare institutions.

**Keywords:** Religious accommodation, minority rights, Muslim-friendly dress-code, halal food, prayer facilities

## Introduction

The right to freedom of religion is inscribed in Article 18 of *The Universal Declaration of Human Rights 1948*. This includes the right to manifest one's religion in daily life.<sup>1</sup> The Pew Research Centre estimated that 83.7 per cent of the earth's population are religiously affiliated.<sup>2</sup> It is important to safeguard

their right to practice their religion, as denying that right may affect the majority of the earth's populace.

Islam is the second major faith in the world. In 2010, it was estimated that about 1.6 billion people are Muslims, accounting for 23.2 per cent of the world's population. The majority of Muslims reside in the Asia Pacific region (972.5 million or 24.1 per cent of the region's population), followed by the Middle East – North Africa (315.3 million or 91.2 per cent of the region's population), Sub-Saharan Africa (240.6 million or 30.1 per cent of the region's population), Europe (38.1 million or 5.2 per cent of the region's population), and the Americas (4.6 million or 0.5 per cent of the region's population).<sup>3</sup> For Muslims, Islam should govern every aspect of their lives rather than being limited to specific rituals or acts of worship. Dietary rules, five obligatory daily prayers, dress codes and other Islamic conventions are expected to be fulfilled unless exemptions have been prescribed.

One may generally presume that Muslims are more likely to receive better religious accommodation in Muslim-majority rather than Muslim-minority countries. However, is this really the case? This paper aims to identify factors that support and oppose the provision of religious accommodation for Muslim healthcare personnel and recipients of healthcare in Muslim-minority and Muslim-majority countries. For the purpose of the study, medical, nursing, and allied health sciences students are included in the definition of healthcare personnel. The study focuses on the accommodation of three basic Muslim needs: provision of halal food, prayer facilities, and the presence of a Muslim-friendly dress code. With regards to the dress code, this study is focusing only on workplace attire and excludes other parameters, such as body grooming, trimming nails and wearing jewellery. This qualitative study utilises document analysis and secondary data analysis to evaluate the topic. The study employs a library research method to gather relevant literatures on religious accommodation for Muslims in healthcare, which includes journal articles, reports, theses, books, newspaper articles and the websites of relevant organisations. Based on the secondary data, practical examples and reasons for religious accommodation and non-accommodation are identified. The data is then analysed through thematic analysis to classify factors associated with the likelihood of religious accommodation for Muslim patients and healthcare workers.

The paper begins with an elaboration of the concept and practice of halal food, obligatory prayers and dress rules in Islam. Next, the findings are presented, followed by the concluding remarks.

## Selected Issues on Muslims' Needs in Healthcare

### Dietary rules

Food safety and the consumption of wholesome food are recommended in Islam for maintaining spiritual, mental and physical well-being. The Islamic doctrine prescribes certain dietary rules by emphasising the concept of *halalan* (permissible) while also recommending *tayyiban* (wholesome). The Qur'an commands human beings to "Eat from good things (*tayyibat*) which We have provided you" (Al-A'raf 7:160). In chapter Al-Baqarah, it is articulated that, "O mankind, eat from whatever is on earth (that is) lawful and good and do not follow the footsteps of Satan. Indeed, he is to you a clear enemy" (Al-Baqarah 2:168). The principal dietary rule in Islam is that everything is halal unless its prohibition is clear or the consumption would lead to adverse consequences. Food which would lead to adverse consequences includes harmful, intoxicating (such as alcohol), filthy, naturally repulsive or unlawfully acquired substances. Porcine-based products are prohibited completely. Additionally, there is another criterion prescribed for making animal meat halal, which is the Islamic way of slaughtering. Seafood is permitted to be consumed without the need for slaughtering. Utensils that have been in contact with porcine-based products are considered contaminated and need to be washed thoroughly before they may be used to prepare or serve halal food.<sup>4</sup>

### Obligatory prayers

Muslims are commanded to pray five obligatory prayers at specific times of the day as an act of obedience to God. These daily obligatory prayers are considered one of the five pillars of Islam and there is no means of forgoing them. This rule necessitates the provision of prayer facilities for Muslim patients and healthcare personnel. It is worth noting that in the absence of a specifically designated space for prayer, Muslims may perform their prayers anywhere, as long as the place is clean. Except for the Friday prayers for men, Islam does not mandate Muslims to attend congregational prayers at a mosque; the daily prayers may be performed individually from five to ten minutes each. In addition, under special circumstances (such as sickness), Muslims are allowed to combine the day and night prayers, thus praying only three times a day. Those who are sick and do not have the strength to stand may pray in a sitting or lying position.<sup>5</sup> These corresponding exceptions profoundly ease the fulfilling of the religious obligation of prayer.

Additionally, while praying, a Muslim must be in a state of cleanliness, which is attained through *wudu'* (minor ablution) or *ghusl* (major ablution),

which involves the washing of certain body parts. The ablution requirement may sometimes create difficulties for some institutions due to the absence of specific washing facilities.

### **Dress code**

The clothing etiquette for Muslim men and women is considered a manifestation of being a devout Muslim. Muslims are required to cover their *awrah* (intimate body parts that must be covered to preserve modesty, a cherished virtue), which extends from the navel to the knees for men, and all parts of the body for women, except the face and hands (while some scholars also include the feet). The latter includes in public and in the presence of men who are not their husbands nor belong to a specific group called *mahram* (non-marriageable male relatives).<sup>6</sup>

Since the extent of a woman's *awrah* is greater than a man's, issues related to dress in healthcare institutions – which conforms to strict hygiene standards – more commonly affect women. For example, the commonly practiced bare-below-the-elbow policy (which enables easier hand washing and prevents cross-contamination between patients) is an issue for Muslim women healthcare employees but non-problematic for Muslim men. However, uncovering the forearms for infection control measures is unnecessary for healthcare employees when they are not directly involved in clinical procedures. Even when they do, there are other means of covering them while still complying with hygiene standards (such as the use of long-sleeved aprons or disposable over-sleeves).<sup>7</sup> Another issue regarding dress code for Muslim female healthcare employees is the headscarf. However, the use of a headscarf does not infringe clinical hygiene standards as long as it is clean and not dangling. It is only problematic from the perspective of corporate image and uniformity.<sup>8</sup>

### **Special situations allowing relaxation of rules regarding unlawful acts**

In specific situations called *darurah*, rules (including dietary and dress code) become more flexible to cater to more important interests.<sup>9</sup> The *darurah* entitlement is relevant when it affects one's life or health, after taking the opinion of Muslim medical experts on the likelihood of the anticipated effect and after confirming that there is no other permissible alternative that could save one's life or health (in the context of healthcare). For example, a Muslim is allowed to expose his/her *awrah* during physical examination or other clinical procedures. However, Muslim patients and employees of healthcare institutions still require facilities to observe the rules when the situation does not fulfil the criteria of *darurah*.

## Results and Discussion

There are few published studies on religious accommodation in Muslim-majority countries. In the context of Malaysia, Saidun has reported that prayer facilities and gender-segregated wards are present in ten anonymised maternity centres which profess to be Shariah-compliant. However, three maternity centres were found to be insensitive towards ensuring a patient's *awrah* is not exposed unnecessarily, while six institutions did not have comprehensive *awrah*-covering dress codes for Muslim female personnel.<sup>10</sup> An internal survey involving patients, patients' relatives, and healthcare personnel in the Al-Islam Hospital (a private hospital) in Kuala Lumpur, Malaysia, demonstrated that 82 per cent of respondents opined that the hospital complied with Islamic culture, which fifteen per cent felt the opposite and the rest were undecided.<sup>11</sup> Raimi recalled her experience as a doctor in Johor Bharu General Hospital, Malaysia, in 1980, when the head nurse at the operation theatre prohibited her from wearing a headscarf, although the surgeon subsequently gave his permission.<sup>12</sup> In another Muslim-majority country, Albania, Jazexhi stated that halal meals are not served in public institutions and hospitals.<sup>13</sup> These limited findings suggest that Muslims' needs are not always accommodated in healthcare institutions in countries where the majority of the population is Muslim.

On the other hand, a few studies provide information on the level of religious accommodation in Muslim-minority countries. A study by the Open Society Foundations in 2010, involving eleven cities in six European countries, suggested that Muslims were of the opinion that religious customs were generally well-respected. When the participants were asked "Do hospitals and clinics respect different religious customs?" about 14.1 per cent of Muslim respondents (n=1110) chose the answer "too little", while 21 per cent were undecided. A majority of respondents (60.3 per cent) chose the answer "about right", and 4.6 per cent answered "too much".<sup>14</sup> In Paris (one of the eleven cities), the report stated that participants experienced various degrees of accommodation in different healthcare institutions and different sections or departments within an institution.<sup>15</sup> The situation in Belgium also illustrated differences in religious accommodation at various levels of the administration. Although there is no national law prohibiting the wearing of a headscarf in Belgium, the city of Antwerp bans headscarves in public offices. However, a hospital in Antwerp tries to accommodate Muslim dress requirements to a certain extent by allowing neck-exposing head covering for its personnel.<sup>16</sup> In Australia, the Human Rights and Equality Commission reported the experience of a midwife who was told by a nursing manager to remove her headscarf in the operation theatre but later gained permission from the supportive management, who subjected the

nursing manager to counselling.<sup>17</sup> Additionally, published studies suggest there is evidence of improvement when it comes to religious accommodation. Anwar and Bakhsh highlighted that some of the respondents in Britain have witnessed improvements in religious accommodation in healthcare facilities.<sup>18</sup> In Sweden, Sander reported an improvement in awareness regarding Muslims' religious needs, although some of the Muslim respondents stated that they still experience instances of low level awareness in some Swedish institutions.<sup>19</sup> The above studies reveal that religious accommodation is present in healthcare institutions where research had taken place, and improvements have been observed over time.

The above account demonstrates that religious accommodation in healthcare involves multi-level commitments, as shown in Figure 1. The degree of religious accommodation in healthcare varies between different countries and different states, and does not merely depend on the religion of the majority of the populace. A government formulates laws and determines policies for the nation or state. The ruling prohibiting halal meals in public institutions in Albania is an example that demonstrates governmental influence in determining religious accommodation for Muslims. Even within one country or state, various institutions provide different levels of religious accommodation, as depicted in the case of Belgium above. At the next level, the management of healthcare institutions formulate ethical codes, prepare practice standards, allocate resources and take action on any violation of regulations at the institutional level. Healthcare personnel, on the other hand, create an institutional culture. This culture may originate from the top management or subordinate personnel dealing directly with healthcare personnel or patients of Muslim origin. This results in the variation of religious accommodation between different sections within an institution and different personnel within the same department, as illustrated by the aforementioned cases in Malaysia and Australia. Given this context, it is important to identify the exact origin of resistance towards providing religious accommodation, and find ways to overcome that resistance. It is most effective if the individual dealing directly with the Muslim healthcare personnel or patient approves of religious accommodation, even if the higher authorities disapprove of it. On the contrary, if the higher authorities generally allow for religious accommodation, but the one who deals directly with Muslim patients or staff disapproves of it, further permission should be obtained from the higher authority. For example, Macháček reports that a healthcare worker in the Czech Republic who converted to Islam was able to continue working at her hospital only after she won a court case against it for unfair dismissal due to her wearing a headscarf.<sup>20</sup> However, pursuing the higher authority's approval may be time-consuming, and financially and emotionally exhausting.

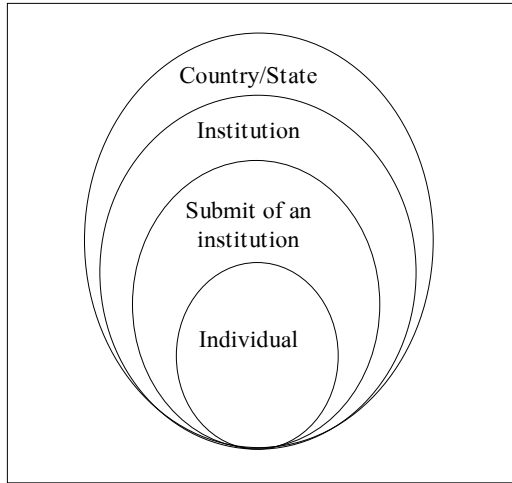


Figure 1. The likelihood of accommodating Islamic religious needs depends on the country or state, the institution, the subunit of that institution, and the individual approving the accommodation.

Besides the varying degrees of accommodation granted at different levels of the administration, there are numerous other factors which affect the likelihood of religious accommodation being provided at a healthcare institution. Based on an analysis of these factors, we classify them into four groups: knowledge, attitude, rules and standards, and resources. These all directly influence each other and consequently determine the quality of religious accommodation.

### **Knowledge**

Insufficient knowledge manifests in the form of misconceptions and low levels of awareness about Islamic rulings. This creates a significant obstacle in accommodating religious needs in the healthcare system.

Public awareness, knowledge, and understanding of Islamic practices are prevalent in Muslim-majority countries, even among non-Muslim citizens because they have daily interaction with Muslims and are exposed to Islamic practices on a regular basis.<sup>21</sup> Thus, there is no need for Muslims to request halal food, prayer breaks, or the minimising of physical exposure between genders, as these needs are already generally understood and accommodated.<sup>22</sup> In Malaysia, healthcare institutions organise Islamic educational programmes for employees to improve their awareness, knowledge, and understanding of Islamic rituals.<sup>23</sup>

Expatriate nurses in the Kingdom of Saudi Arabia reported having briefing sessions during their interviews with recruiting agents, as well as during orientation programmes and cultural competency workshops, that helped them gain awareness, knowledge, and understanding of the indigenous culture and religion.<sup>24</sup> However, there are also cases of low levels of awareness, knowledge, and understanding of Islam in some Muslim-majority countries, as indicated in earlier studies. As the degree of personal religious conviction differs,<sup>25</sup> the level of Islamic knowledge among Muslims varies from one person to another. Hence, some Muslims and non-Muslims in Muslim-majority countries may have insufficient knowledge or misconceptions about Islamic principles and practices, as demonstrated by studies conducted in Malaysia and Saudi Arabia.<sup>26</sup>

In Muslim-minority countries, a satisfactory level of awareness and understanding of Islamic principles among healthcare providers enables Muslim healthcare personnel and patients to receive basic accommodation for religious practices during clinical encounter. In the last few decades, various types of leaflets, guidelines and books on Islam and its principles have been published by health authorities, non-governmental organisations, and Muslim activists.<sup>27</sup> This topic also receives wide attention among academicians and has been thoroughly discussed in scholarly journals. Besides, cultural competency training is conducted in various institutions to improve healthcare personnel's knowledge and skills when dealing with recipients from diverse backgrounds.<sup>28</sup> Working with Muslims exposes non-Muslims to Islamic practices as well.<sup>29</sup> Nevertheless, earlier studies in the field indicated an unsatisfactory level of awareness, knowledge, and understanding of the needs of healthcare workers and patients of Muslim origin among non-Muslim healthcare service providers. Hasnain *et al.* reported that 93.8 per cent (n=27) of Muslim patients in their study in the United States perceived that their religious or cultural needs were not understood by healthcare providers. The lack of knowledge among healthcare providers about the religious needs of Muslims is one of the main factors that led to a decline in the rights of Muslims to obtain religious accommodation.<sup>30</sup> Lorcerie and Geisser reported that in Marseilles, France, the Islamic halal dietary law has been misunderstood as a prohibition against consuming pork alone.<sup>31</sup> Cortis observed a similar misunderstanding among nurses in the United Kingdom.<sup>32</sup> In fact, non-Muslims may have different level of understanding regarding issues related to Islamic female dress code and animal slaughtering.<sup>33</sup> At the same time, Muslims might find it difficult to explain the religious needs of Muslims to non-Muslims.<sup>34</sup> Such a reluctant attitude on the part of Muslims is mainly due to the secular approach of non-Muslim communities, as they hardly accept religion-based explanations and often demand rational justifications for religious practices.<sup>35</sup>



The above comparison illustrates that awareness of Islamic rituals depends on the knowledge and familiarity of a person with the religion of Islam itself. At the same time, high levels of awareness, knowledge, and understanding of Islamic teachings are not necessarily associated with being a Muslim. Therefore, healthcare institutions must endeavour to provide competency training to equip healthcare personnel with essential knowledge and skills in promoting good care to a culturally diverse population.

### **Attitudes**

Besides knowledge, the attitudes of employers or service providers also determine the likelihood of religious accommodation. Muslim patients and healthcare personnel experience both favourable and non-favourable attitudes towards religious accommodation in healthcare institutions in Muslim-majority and Muslim-minority countries.

It is not surprising that the attitudes of the masses towards Islam and Islamic practices are positive in Muslim-majority countries. Unlike in Muslim-minority countries, the commonly practised daily prayers and Muslim female dress code may not be perceived as problematic.<sup>36</sup> But surprisingly, negative attitudes towards Islam and practising Muslims have been documented in some Muslim-majority countries as well. In Albania, for example, school textbooks do not always present Islam in a positive way.<sup>37</sup> In Malaysia, there is a perception that the Muslim female dress code could compromise hygiene precautions and clinical care.<sup>38</sup> As Muslim-majority countries are mainly categorised as either developing or less developed countries, increased accessibility and delivery of medical treatment are perceived as vital, and are often prioritised over religious accommodation, as in Malaysia.<sup>39</sup> Separation of religion from public life is also prevalent in some Muslim-majority countries, thus shaping the attitudes of the general public regarding religious needs. In the case of Kosovo, and previously in Tunisia and Turkey, secularism resulted in the constitutionality of hijab bans.<sup>40</sup>

The availability of religious accommodation in Muslim-minority countries depends on the attitudes of hospital personnel towards foreign religions like Islam and to Muslims as migrants or minorities in the country. Today, the number of healthcare personnel of Muslim origin is increasing in Muslim-minority countries.<sup>41</sup> Having superiors from the same religious background may be a factor in enabling Muslim healthcare personnel obtain better religious accommodation in their workplaces. Likewise, the presence of Muslim personnel in healthcare institutions may facilitate the needs of Muslim patients.<sup>42</sup> Societies become more exposed to religious diversity when migration and religious conversions take place.<sup>43</sup> Such interactions may

influence public attitudes towards minority religious groups. In most European countries, the healthcare of minority groups has gained attention in public health institutions, as health disparity among minorities is well documented.<sup>44</sup> The lack of culturally sensitive care has been pointed out as one of the reasons for avoidance of healthcare amongst minorities.<sup>45</sup> Thus, culturally competent care has been introduced as an initiative to reduce health disparities.<sup>46</sup> Although the initiatives are aimed at minority ethnic groups rather than religious ones, the religious needs related to a particular ethnic group may be included in considerations.<sup>47</sup> The right to practice religious rituals in healthcare institutions is generally recognised and discrimination on the basis of religious beliefs is disapproved of.<sup>48</sup> Realising the symbiosis between health, culture and religion, holistic patient care and culturally competent care concepts have been introduced in various healthcare institutions, which attempt to accommodate Muslims' needs, such as their dietary needs, prayer needs and Muslim dress code needs.<sup>49</sup> At the same time, specific Islamic obligations sometimes coalesce with local preferences and practices. For example, the patients' right to minimise physical exposure with the opposite gender during clinical procedures or have access to halal food are also accepted and preferred by some non-Muslims, as they hold modesty in high regard, and perceive halal products as of better quality.<sup>50</sup> This has established positive attitudes towards Muslim religious needs, resulting in accommodation. However, negative attitudes are also prevalent and have been well-documented. The mainstream tends to view religious practices as irrational to be confined to the private life of individuals, rather than publicly displayed. This has made accommodation difficult. So too has the perception that religious accommodation is the responsibility of religious institutions and not the state.<sup>51</sup> The delivery of health services, which is the primary concern of healthcare institutions, is thus prioritised over the need to provide religious accommodation.<sup>52</sup> Moreover, some religious needs and etiquettes may be perceived as interfering with providing care or performing work effectively. For example, as mentioned it has been suggested that long sleeves and headscarves may compromise hygiene, while prayer obligations are also seen as interfering with working schedules.<sup>53</sup> When there is a conflict between adhering to religious convictions and job performance, healthcare personnel are expected to prioritise work over personal religious concerns.<sup>54</sup> Among 1,088 non-Muslim respondents to a study conducted in eleven European cities, 7.1 per cent stated that healthcare institutions show "too little" respect for different religious customs in general.<sup>55</sup> This figure suggests that other religious observers have also experienced obstacles when obtaining religious accommodation in healthcare institutions. However, the percentage of Muslim respondents who experienced "too little" respect for religious needs

by healthcare institutions was much higher, standing at 14.1 per cent. The same study also found that 1 per cent of non-Muslims and 4 per cent of Muslims had experienced unfair treatment due to their religious background, implying that there was greater discrimination against the followers of Islam compared to those of other religions. The recent rise of Islamophobia and the anti-migration attitude of many Muslim-minority countries have also contributed greatly to the unfavourable religious accommodation of minorities in general, and Muslims in particular. The growing public disposition to Islamophobia, due to the tragedy of September 11, and the massive migration of Muslims from war-torn and poverty-affected countries to Europe and the USA, has led to discrimination, religious intolerance, and a lack of sensitivity towards religious needs. This jeopardises the rights of Muslims in various spheres, including employment and healthcare.<sup>56</sup> Studies indicate that the lack of religious accommodation could be linked to governments' efforts to stop various alleged threats to their countries, including Islamisation, radicalisation, counter-integration, demands for special treatment, and threats to local culture.<sup>57</sup> Additionally, individuals may harbour negative attitudes towards specific Islamic practices rather than Islam as a whole, as those practices may seem to contradict their normative beliefs. The Muslim female dress code and halal slaughtering are examples of practices that are not well accepted in Muslim-minority countries on the basis of gender discrimination and animal cruelty.<sup>58</sup> In Belgium, for example, campaigns against halal slaughtering without pre-stunning the animal have been launched by animal rights and veterinary associations.<sup>59</sup> Public attitudes towards slaughtering without pre-stunning led to calls by a minister to end such practices in Belgium, which was a political strategy to win over far-right voters.<sup>60</sup> Another Islamic practice that is perceived negatively is the ablution or ritual cleansing; some Muslims wash their feet in the sink, which may be considered socially offensive, unhygienic, and also pose a safety threat as water dripping from the feet causes the floor to be wet and slippery.<sup>61</sup>

These accounts once again suggest that the attitudes which influence the provision of religious accommodation are not merely related to the religion of the majority of the populace. Perceptions towards religion in general, and Islam and Muslims in particular, as well as the specific practices mandated by Islam, affect the attitudes of society and translate into accommodation or non-accommodation of Muslim needs. The issues of immigration and Islamophobia – which also determine the likelihood of accommodation – are more prominent in Muslim-minority countries.

## Standards and regulations

Standards and regulations are highly influential in determining the likelihood of religious accommodation in healthcare. Examining legal regulations, ethical stances, and practice standards or norms help shed light on the matter.

Legal, ethical, and practice standards contradicting Islamic teachings are less prevalent in Muslim-majority countries. Preventing unnecessary physical exposure is one of the practice standards in Oman and Saudi Arabia.<sup>62</sup> The Ministry of Health in Malaysia has ensured that all food served at public hospitals is halal, and visitors are not allowed to bring non-halal meals into the hospitals.<sup>63</sup> Taking time off work to pray on time is acceptable in Muslim countries, with non-Muslim colleagues commonly taking over work while Muslim healthcare employees are praying.<sup>64</sup> Covering of the *awrah* at work to conform with Islamic dress rules is accepted for female personnel in healthcare institutions.<sup>65</sup> Yet, there are also Muslim-majority countries whose legal, ethical, and practice standards do not support religious accommodation. Headscarves have been, until recently, banned in Muslim-majority countries like Turkey, Tunisia, and Kosovo.<sup>66</sup> From the ethical standards point of view, conventional ethical codes conforming to Shariah rules, such as minimising exposure of the body during medical procedures, may not be fully practised even though they are widely accepted.<sup>67</sup> Regarding society's practice standards, Islamic practices may not be commonly practised by the public, especially in post-socialist countries. Thus, non-practising Muslim personnel and patients contribute to unfavourable practice in healthcare institutions. For example, since most patients do not mind being physically exposed for examination without seclusion of the examination space, healthcare personnel commonly examine all patients without ensuring privacy. This has become an institutionalised work culture in one hospital in Malaysia.<sup>68</sup> Other examples of widespread practice standards that do not favour religious accommodation include the banning of headscarves in the operation theatre<sup>69</sup> and prohibiting public institutions from serving halal meat.<sup>70</sup>

Similarly, the legal, ethical, and practice standards in Muslim-minority countries may either promote or hinder religious accommodation. The recognition of the human rights of health and medical care receivers and providers, without any religion or racial discrimination, is directly related to the accommodation of cultural and religious needs in healthcare, as well as the reduction of health disparity. Furthermore, acceptance of the intrinsic human right to practice religion, and the recognition that religious practices may provide for individual well-being, will encourage religious sensitivity and tolerance in secular hospitals. For example, anti-discrimination laws ensure the fair treatment of minorities.<sup>71</sup> In Austria, the "Islam Law" enacted

by the government safeguards the rights of Muslims in numerous respects, including by regulating halal food and its availability in public institutions, including public healthcare institutions.<sup>72</sup> Legal exceptions to stunning prior to slaughtering are granted for religious purposes in authorised slaughterhouses in France and Belgium.<sup>73</sup> Additionally, ethical and practice standards which coincide with Muslims' needs facilitate religious accommodation, like the example mentioned earlier of minimising physical exposure during medical procedures. In addition, current practice standards in healthcare institutions that incorporate religious-sensitive care standards may facilitate religious practice among Muslims, as discussed above.<sup>74</sup> There are also instances where healthcare institutions accommodate all Muslims regardless of their level of religiosity, such as by providing halal meals even if the individual patient does not adhere to the Islamic dietary rules.<sup>75</sup> A hospital in Denmark serves only halal meat to all its patients and staff, including non-Muslims.<sup>76</sup> Having such consideration for religious accommodation enables Muslims to practice their religious obligations easily. However, the legal regulations, ethical stances, and practice standards at healthcare institutions may also become obstacles to Muslims religious accommodation. In certain countries, headscarves and halal slaughtering without pre-stunning or anaesthesia are banned based on secular policies (religious identity prohibition at work) and animal protection laws (the halal slaughtering technique).<sup>77</sup>

Another obstacle for Muslims is the absence of legal or ethical rights to demand religious accommodation in healthcare.<sup>78</sup> The ethical justifications given to promote the face-veil ban include impracticality, a hindrance to integration, a hindrance to identification, a threat to security, and a hindrance to communication due to obscured facial expression and eye contact.<sup>79</sup> The headscarf is also rejected by some in Lithuania and the Czech Republic on the grounds that it constitutes male-imposed oppression towards women and a violation of hygiene policies, unified dress code policies, and of secular policies by wearing religious symbols in public.<sup>80</sup> Furthermore, Islamic practices may contradict work-related codes, such as, policies designed to maintain uniformity in a corporate image and that may prevent Muslim healthcare personnel from wearing long-sleeved attire or headscarves.<sup>81</sup> Instead of accommodating Islamic practices, patients and healthcare personnel are expected to adapt to prevailing rules or long-established standards.<sup>82</sup>

Regulations and policies contradicting the practices prescribed by Islam may become obstacles for practising Muslims. Furthermore, institutional cultures may facilitate or hinder religious accommodation in healthcare regardless of the presence or absence of any formal policy or regulation. Laws that prohibit Islamic practices, as discussed above, are more common in Muslim-minority

countries. Some of these laws may even be used to justify either accommodation or non-accommodation. For example, the principle of anti-discrimination is used to justify the accommodation of wearing a headscarf, but the same principle is also used to ban the practice as male-imposed discrimination against women, as elaborated above.

## Resources

Inadequate resources may become a hindrance to accommodating Muslim religious needs in healthcare institutions. The issues that emerge here are related to financial, human and material resources.

Many Muslim needs are widely available in healthcare facilities in Muslim-majority countries. Greater access to halal food and prayer facilities are common among healthcare institutions in Muslim-majority countries. In Malaysia, certain healthcare institutions provide headscarves to be used by their female Muslim patients in the operation theatre.<sup>83</sup> The presence of experts in Islamic studies facilitates continuous Islamic education programmes organised by healthcare institutions.<sup>84</sup> However, there are healthcare institutions in Muslim-majority countries which have limited financial, material, and human resources to accommodate Muslim religious needs. This is common in less developed Muslim-majority countries. Disposable over-sleeves that female Muslim healthcare personnel can use to cover the forearm during procedures that require them to wash and expose the forearm for hygiene purposes may not be available in every institution.<sup>85</sup>

In Muslim-minority countries, economic implications are cited as justifications for accommodating religious needs. In Denmark, for example, the halal industry contributes to the national economy by providing jobs and revenue from both domestic sales and exports of halal food.<sup>86</sup> Certain healthcare institutions in developed countries may have adequate resources and logistics to accommodate the religious needs of their patients and healthcare personnel. The availability of local slaughterhouses and imported halal meat supplies or halal caterers<sup>87</sup> facilitate the availability of halal food at healthcare institutions. The existence of a local halal certification body also contributes greatly to the availability of halal-certified products.<sup>88</sup> The presence of experts in the field of culturally-competent healthcare facilitates cultural-competency training, which helps healthcare personnel understand the religious and cultural needs of others and provide appropriate care.<sup>89</sup> Institutions that have adequate space and facilities are able to designate a common prayer room for the followers of different religions, including Muslims.<sup>90</sup> Besides the public healthcare facilities which are provided by the government, the presence of other types of healthcare facilities

with different motivations may contribute to improved religious accommodation in healthcare. For example, profit may motivate private healthcare institutions to invest their resources in accommodating their customers' religious needs.<sup>91</sup> Humanitarianism may drive charity-based organisations to use their resources to provide culturally-competent services to migrants.<sup>92</sup> However, the limited availability of resources often hinders accommodation. Prayer obligations may not be accommodated due to the perceived notion that it may interfere with the work schedule, with efficiency, and with output. It may also become a source of dissatisfaction among co-workers.<sup>93</sup> In summary, providing these facilities requires financial and material resources that healthcare providers would rather invest in other priority areas.<sup>94</sup>

To enable Muslims to observe their religious obligations, healthcare providers have to allocate a considerable amount of resources to providing appropriate materials, facilities, and competent human resources. Thus, financial implications may play a major role in determining whether accommodation of Islamic practices and Muslim-friendly regulations and standards are feasible. Prayer facilities, halal food, and Muslim-friendly attire cannot be provided without adequate resources.

## Conclusion

Muslims account for a large proportion of the earth's population and are scattered all over the world. Numerous phenomena, such as migration and medical tourism, have led to the globalisation of healthcare. Information technology has also enabled easier and greater access to information about religious practices. Moreover, Islamic propagation activities have led to the religious conversion of indigenous peoples. This results in a greater diversity of the workforce in the healthcare system and also patient population. Sensitivity towards the religious needs of both healthcare personnel and patients is essential for their satisfaction. Healthcare providers must, therefore, manage culturally-diverse healthcare beneficiaries.

The findings discussed in this article highlight that accommodation does not merely depend on the official religion of a country. Sometimes, a Muslim in a healthcare institution in a Muslim-minority country may find it easier to practice Islam than a Muslim working in a healthcare institution in a Muslim-majority country. The likelihood of accommodation depends on the constitutionality of the country or state where the institution is situated, the institution itself, the sub-units within the institution, and the personnel of the institution. Hence,

individuals seeking religious accommodation in healthcare should become more proactive in obtaining accommodation from the various levels of the administration.

Secondly, the paper groups the factors that influence religious accommodation in healthcare into four main categories: knowledge, attitudes, regulations and standards, and availability of resources at the institution. Advocates may work towards the improvement of these four factors to enhance the degree of religious accommodation in healthcare, to provide a better working environment, and to facilitate healthcare delivery to recipients.

Although this paper only focuses on Muslim religious accommodation, healthcare providers should also be sensitive to the needs of other religious believers. Since the present findings come from a qualitative study, however, generalising them in this regard is difficult.

Finally, the paper suggests the following policy recommendations:

- Muslims and the followers of other religions have the right to obtain religious accommodation in their workplaces, whether they live in a Muslim or non-Muslim country. The recognition of the human rights of health care receivers and providers, without any religious or racial discrimination, should be safeguarded in order to achieve social harmony and the well-being of society. Acceptance of the intrinsic human right to practice religion, and the recognition that religious practices encourage the promotion of religious sensitivity and tolerance in secular hospitals should be acknowledged. These rights should be safeguarded by the state, in particular by using anti-discrimination laws to ensure the fair treatment of all, including minorities.
- To promote equality and inclusion in increasingly diverse populations, national education systems ought to play a role in fostering religious and racial tolerance, not only for the sake of Muslims, but for all religious and racial groups. Educational institutions should work together with religious communities (especially in the case of minority groups) to combat social hatred, racism, religious discrimination and xenophobia. The inclusion of cultural and religious needs in medical and allied health sciences curricula is also recommended.
- The media should be actively utilised to raise public awareness of the religious needs of minority groups in Muslim-minority countries. Non-Muslim public perceptions towards religion in general, and Islam and Muslims in particular, and the specific practices mandated by Islam,



affect the attitudes of society towards the accommodation or non-accommodation of Muslim needs.

- Since insufficient awareness, inadequate knowledge of religious and cultural needs, and misconceptions about Islamic principles are the main factors for a lack of religious accommodation in healthcare, institutions must provide competency training to equip healthcare personnel with essential knowledge and skills regarding culturally diverse populations. Thus, additional cultural-competency training courses are required for healthcare personnel in order to create culturally-competent healthcare institutions.
- To enable Muslims to observe their religious obligations, healthcare providers have to allocate considerable resources for appropriate materials, facilities, and competent human resources. Inadequate resources may become a hindrance to accommodating Muslim religious needs in healthcare institutions. Prayer facilities, halal food, and Muslim-friendly attire cannot be provided without adequate resources. Dialogue should exist with Muslim employees or patients to brainstorm potential means of fulfilling their needs, either directly or through alternative ways (such as providing vegetarian meal instead of halal meat or enabling Muslim female personnel to use self-bought disposable over-sleeves to cover the forearms). In circumstances where resources are limited or need to be prioritised (especially in Muslim-minority countries), institutions may work with local Muslim organisations to explore alternative ways to obtain the required resources to provide the necessary facilities.

## Notes

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