The Impact of Practicing Both Medicine and Religion: Muslim Identity as a Predictor of Discrimination, Accommodation, and Career Outcomes in Academic Medicine

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Purpose: Workplace discrimination is receiving increased attention within health care; however, most research focuses on racial/ethnic, sexual, and gender identities.[1–3] With Muslim Americans comprising over 5% of the physician workforce and an ongoing sociopolitical climate of Islamophobia, it is critical to investigate how Muslim identity relates to physician experiences in academic medicine. In this study, we assessed the relationships between religiosity and perceived discrimination and accommodation in the workplace, along with several sociodemographic factors and job-related outcomes.

Method: Physicians from 3 American Muslim professional organizations (Islamic Association of North America, American Muslim Health Professionals, and U.S. Muslim Physician network) were recruited to complete a 15-minute online survey. Inclusion criteria included being a practicing physician in the United States, self-identifying as Muslim, being English-proficient, and having worked at a university-affiliated hospital, teaching hospital, or other academic health care institution within the last 20 years. The survey instrument probed religiosity as the primary predictor domain with a validated religious importance item and the Duke University Religion Index (DUREL) composed of 3 subscales (congregational religious activities, private religious activities, and intrinsic religiosity). Outcomes included workplace discrimination and accommodation, job turnover, career satisfaction, burnout, depression, belonging, and workplace motivation using validated items. Conventional sociodemographic characteristics were collected and treated as co-variates. Bivariate linear and logistic regressions were used to analyze the relationship between religiosity measures and sociodemographic characteristics with the outcomes. All predictors that were significant at $P < .10$ in bivariate models were then included in multivariate regression models.

Results: Two hundred sixty-four participants completed the survey with a mean age of 39.5 years, most were male (61%), born in the United States (55%), completed medical school in the United States (72%), had a visible marker of Muslim identity, that is, beard or hijab (51%), and Sunni (70%). Fifteen percent identified as African American/Black, 21% as Arab/Arab American, 31% as South Asian, and 27% as European/White. Multivariate models revealed that religious importance was associated with several critical outcomes while controlling for the DUREL items and various sociodemographic factors. Religious importance was positively associated with discrimination from patients (OR = 3.78, $P = .02$, 95% CI [1.25, 11.43]) and depression (OR = 5.36, $P = .002$, 95% CI [1.84, 15.58]) and negatively associated with prayer accommodations in the workplace (OR = .20, $P = .001$, 95% CI [0.08, 0.52]). Engaging in congregational religious activities was negatively associated with discrimination from patients (OR = .64, $P = .006$, 95% CI [0.47, 0.88]) and job turnover (OR = .63, $P = .02$, 95% CI [0.43, 0.92]) and positively associated with accommodations for prayer (OR = 1.42, $P = .008$, 95% CI [1.09, 1.84]) and general religious identity accommodation (OR = 1.47, $P = .01$, 95% CI [1.09, 1.98]). Finally, multivariate models also revealed significant differences between experiences and outcomes based on race/ethnicity. African Americans reported experiencing more workplace discrimination, job turnover, burnout, and depression when compared with Arabs, South Asians, and Whites.

Discussion: Our findings demonstrate that greater religious importance among Muslim physicians is linked to multiple negative outcomes in academic medicine including higher levels of workplace discrimination and depression, and less accommodation in the workplace for prayers. On a positive note, greater involvement in religious congregational activities is linked to lower perceptions of workplace discrimination and discrimination from patients, as well as positive perceptions of being religiously accommodated at work. Religious importance appears to attract negative experiences, while greater religious practice seems to buffer against them. Finally, African American racial identity compounds negative outcomes.

Significance: Our study documents how Muslim religious identity negatively impacts workplace experiences and well-being in academic medicine. However, religious practice mitigates negative outcomes. Thus, there is an urgent need for academic medical centers to ameliorate workplace discrimination and pursue policies of workplace accommodation for physicians with strong religious identities. Indeed, the goals of workplace equity and inclusion demand so.

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