


RESEARCH ARTICLE

Muslim American physicians' experiences with, and views on, religious discrimination and accommodation in academic medicine

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Abstract

Objective: To assess Muslim physician experiences with religious discrimination and identify strategies for better accommodating Muslim identity in health care.

Data Sources and Study Setting: Interviews were conducted with Muslim physicians from three US-based Muslim clinician organizations between June and August 2021.

Study Design: In-depth, semi-structured qualitative interviews used a phenomenological approach to describe experiences of religious discrimination and accommodation. A team-based framework approach to coding was used to inductively generate themes from interview data.

Data Collection/Extraction Methods: Physicians from the Islamic Medical Association of North America, American Muslim Health Professionals, and the US Muslim Physicians group were invited to participate using closed organizational listservs. Inclusion criteria sought English-speaking, self-identifying Muslims with current or past affiliation with a university hospital in the United States. Potential participants were segmented into groups based on responses to questions about perceived religious discrimination and accommodation. Purposive sampling was used to iteratively approach participants within these groups in order to capture a diverse respondent pool. Interviews stopped after thematic saturation was reached.

Principal Findings: Eighteen physicians (11 women and 7 men; mean age: 41.5 [standard deviation = 12.91] years) were interviewed. Nearly all ($n = 16$) held Islam to be important in their lives. Three overarching themes, with several subthemes, emerged. Participants (1) struggled to maintain religious practices and observances due to unaccommodating organizational structures; (2) experienced religious discrimination, which, in turn, impacted their professional trajectories and, at times, their personal well-being; and (3) believed that institutions could implement specific educational and policy interventions to advance the religious accommodation of Muslims in health care.

Conclusions: Muslim physicians frequently encounter religious discrimination, yet there are concrete ways in which health care workplaces can better accommodate their religious needs and combat discrimination. To improve workforce diversity,

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equity, and inclusion, educational forums and policies that support the religious practices of physicians need to be established.

KEYWORDS

accommodation, diversity, inclusion, Islam, prejudice

What is known on this topic

- Workplace discrimination is oft-experienced by physicians and trainees from minority backgrounds, and it adversely impacts their career trajectories and personal well-being.
- Combating workplace discrimination is key to enhancing workforce diversity, equity, and inclusion.
- Religious discrimination and Muslim identity are under-addressed by diversity, equity, and inclusion initiatives in American health care.

What this study adds

- Muslim physicians encounter religious discrimination and lack of religious accommodation at multiple levels within the health care workplace.
- Physician trainees' negative experiences are compounded by their vulnerable status, deterring them from asking for religious accommodations.
- Employing strategies such as work schedule flexibility and dedicated prayer spaces can contribute to more accommodating workplace environments for Muslim physicians.

1 | INTRODUCTION

Muslim Americans represent an important part of the US health care workforce, with over 5% of physicians estimated to be of Muslim background.¹ Growing anti-Muslim bias and discrimination in society which may spill over into the work environment,² along with increasing numbers of clinicians leaving the workforce,³ lends importance to studying how Muslim identity intersects with workplace discrimination, as well as to examining the impact religious discrimination may have on physicians. Indeed, physicians from minority backgrounds frequently experience workplace discrimination⁴⁻⁸ despite efforts at advancing equity and inclusion in health care.^{9,10} These experiences include patients questioning their competence or refusing their care, to invidious scrutiny by colleagues and supervisors,¹¹⁻¹⁴ and encountering manifold microaggressions¹⁵ including racist and demeaning comments.⁵ Physicians from minority backgrounds tend to confront biases from their leaders, colleagues, and patients more so than White physicians.^{5,7,16,17}

The negative impacts of workplace discrimination on physicians' well-being are widely documented.^{4,18,19} These include decreased job satisfaction, increased job turnover, and higher stress levels, all of which adversely impact patient care.^{5,8,20} Additionally, structural biases lead to fewer opportunities for minority physicians to advance into leadership, thus exacerbating the lack of education and policy action needed to remedy these issues. Certainly, experiencing discrimination based on race and ethnicity,²¹ gender,²² immigrant status,²³ and sexual orientation²⁴ deepens inequities, and detracts from workforce diversity in health care.

While religion is important to many physicians, workplace discrimination based on religious identity remains understudied,^{25,26} and studies of US Muslim physicians are rare.²⁷⁻²⁹ Examining physician experiences with religious discrimination and institutional responses to the religious needs of physicians can further illuminate how diversity, equity, and inclusion (DEI) can be advanced in the health care workplace. DEI efforts may involve religious accommodations, which are defined by the Equal Employment Opportunity Commission as “any adjustment(s) to the work environment that will allow the employee to practice his or her religion.”³⁰ Consequently, our study aimed to assess Muslim physicians' experiences with religious discrimination and to identify strategies for better accommodating their religious identity in health care.

2 | METHODS

2.1 | Study design

Our community-engaged research³¹ adopted a phenomenological approach^{32,33} to qualitative inquiry in describing physician experiences of religious discrimination and accommodation. This approach informed our sampling frame and recruitment strategy, the design of interview questions, and the methods of data analysis (see below). Human subjects research approval was granted by the institutional review board committee of the Medical College of Wisconsin. In what follows, we utilize the Consolidated Criteria for Reporting Qualitative Research to describe our study.³⁴

2.2 | Participants

We partnered with three national Muslim clinician organizations: the Islamic Medical Association of North America, American Muslim Health Professionals, and the US Muslim Physicians group for participant recruitment. We selected these organizations because their mission and values are informed by Islam and, as such, religious identity may be more prominent for physicians affiliated with these groups. Via emails on closed listservs, members of these groups were invited to participate in our study. Inclusion criteria were (i) being English-speaking, (ii) self-identifying as Muslim, and (iii) being affiliated with a university hospital in the United States within the past 20 years. Respondents received an online screening survey that confirmed eligibility, collected basic sociodemographic and contact information, and contained two sorting questions that elicited perceptions of religious discrimination and accommodation at work (details below). These questions read, “I personally experience discrimination in my current workplace” and “My workplace accommodates my religious identity,” with respondents having to agree or disagree with the statement. Neither religious discrimination nor accommodation was defined so that respondents could reflect on their own experiences without external typologies and thresholds. Notably, racial and ethnic descriptors were self-reported by respondents with categories being African American/Black, Arab or Arab American, South Asian, European/White, or Other. These categories slightly modify census categories based on participant insights garnered from our community-based participatory research in Muslim American communities.

One-hundred eighty-six survey respondents met eligibility criteria and were willing to be interviewed. Respondents were segmented into four groups based on responses to the two sorting questions: high discrimination and low accommodation, high discrimination and high accommodation, low discrimination and low accommodation, and low discrimination and high accommodation. Purposive sampling³⁵ was used to obtain a diverse sample by iteratively offering interviews to potential participants within each group according to their self-reported racial, ethnic, and biological sex characteristics.

We contacted 52 potential participants and thematic saturation was reached after 18 interviews. Interviewees were offered a \$75 gift card or a signed book as remuneration (see Appendix A for greater details on participant flow).

2.3 | Data collection

Informed consent was obtained during an interview scheduling call and participants were offered sex-concordant interviewers. One of three qualitative researchers (LA, AIP, and SM) conducted interviews using a secure teleconference platform from their own private offices with participants situated at a location of their choosing. Teleconferencing was used because the geographic variability of participants and ongoing COVID-19 pandemic made it infeasible to conduct in-person interviews. Among the interviewers, LA is a community health researcher with a PhD in Public and Community Health, SM is a

researcher with a PhD in Social Psychology, and AIP is a physician-scientist with an MSc in health care research. SM and LA identify as Muslim American Palestinian women, while AIP identifies as a Muslim American Pakistani male.

Based on previous research related to discrimination experienced by US Muslim physicians, the investigative team crafted a semi-structured interview guide containing both closed- and open-ended questions (see Appendix B).^{29,36–38} Interview questions probed about religious practices and observances at work; experiences with religious discrimination and accommodation; and best practices and policies for reducing discrimination and improving accommodation. Two academic Muslim physician volunteers participated in mock interviews to pilot-test the interview guide. Questions were revised for clarity based on feedback. The 18 interviews lasted between 32 and 85 min each (mean = 61 min; standard deviation = 14 min), and interviewers took field notes, which were used as adjuncts in thematic analyses. Repeat interviews were not solicited as they were not needed to clarify themes. Interview transcripts were not shared with participants.

2.4 | Analysis

A team-based framework approach to coding was used to inductively generate themes from interview data.³⁹ Bearing in mind interview question stems, interview notes, and recollection of notable participant experiences, a preliminary codebook was developed by the team. This codebook was further refined after two analysts coded the same three transcripts to assess intercoder reliability, and the third analyst reviewed all interview transcripts for significant participant experiences and perspectives that were not covered by existing codes. After achieving an intercoder reliability of >0.80, the remaining transcripts were independently coded.

The first phase of analysis utilized QSR NVivo 12 software.⁴⁰ Interview code summaries were reviewed by the team to group lower-order codes into higher-order themes. Thematic summaries were then evaluated for similarities and differences across the high and low perceived religious discrimination and accommodation groups. Since no significant thematic differences were found, all interviews were treated as a single dataset for content analysis. The second phase of analysis involved the crystallization-immersion technique as a validity check. Independent of NVivo, two analysts (LA and SM) reviewed and created content summaries for all interview transcripts. AIP then validated the content summaries by reviewing all transcripts and highlighting participant quotes that illustrated important phenomena. The content summaries were also compared with NVivo-based content analysis. Analytical disagreements between these two were resolved through negotiated team consensus.

3 | RESULTS

The mean age of the 18 participants was 41.5 years (range: 29–77; standard deviation = 12.91) with an average of 13 years (range:1–56;

TABLE 1 Participant characteristics of Muslim physicians ($n = 18$).

Age in years, mean (range, standard deviation)	41.5 (29–77, 12.91)
Sex	
Male	7
Female	11
Race and ethnicity	
Arab or Arab American	5
South Asian	13
Years in medical practice, mean (range, standard deviation)	12.8 (1–56, 13.98)
Specialty	
Internal medicine and its subspecialties	7
Obstetrics/gynecology	1
Pediatric and its subspecialties	1
Surgical and its subspecialties	1
Psychiatry	3
Other	5
United States residency status	
Born in United States	9
Immigrated to United States as a child	3
Immigrated to United States as an adult	6
Current practice location	
California	1
Connecticut	1
Florida	2
Illinois	1
Michigan	2
Missouri	1
New York	4
Ohio	1
Pennsylvania	1
Texas	4
Importance of religion within one's life	
Most important	12
Very important	4
Fairly important	1
Not at all important	1
Organizational affiliation	
Islamic Medical Association of North America	12
American Muslim Health Professionals	4
US Muslim Physicians group	2
Attended medical school in the United States	
Yes	10
Perceived religious discrimination at work	
High religious discrimination	9
Low religious discrimination	9

TABLE 1 (Continued)

Perceived religious accommodation at work	
High religious accommodation	12
Low religious accommodation	6

Note: Islamic Medical Association of North America, established in 1967, is the largest and most regionally and ethnically diverse association of American Muslim physicians. IMANA aims to promote health equity for Muslim patients and health care professionals. American Muslim Health Professionals is a national network of allied health professionals that seeks to improve public health through efforts inspired by the Islamic tradition. The US Muslim Physicians group is a social network that fosters scholarly exchange and collaboration among American Muslim physicians.

standard deviation = 13.98) in medical practice. Most were female ($n = 11$, 61%) and South Asian ($n = 13$, 72%). Nearly all ($n = 16$, 89%) considered Islam very important to their lives. The sample was split almost evenly among international ($n = 8$, 44%) and US medical graduates ($n = 10$, 56%) (Table 1).

Three broad themes, with several subthemes, related to religious identity discrimination and accommodation in the health care workplace emerged. The first theme is that Muslim physicians struggled to maintain religious practices and observances due to unaccommodating organizational structures. Five subthemes related to this idea emerged: (1) finding time to perform ritual prayers is hard; (2) attending Friday prayer services is complicated; (3) adjusting work schedules to accommodate Ramadan fasting is not easily done; (4) Islamic holidays are not formally recognized; and (5) Muslim dietary needs are largely ignored by the workplace.

The second theme was that participants experienced religious discrimination, which, in turn, impacted their professional trajectories and, at times, their well-being. Related subthemes included: (1) patients, colleagues, supervisors, and the institution, each, can discriminate against Muslim identity; (2) religious discrimination negatively impacts physicians' careers, health, and religiosity; and (3) participants were unsatisfied with institutional responses to their complaints of religious discrimination.

The final theme was that participants believed that institutions could implement specific educational and policy interventions to advance the religious accommodation of Muslims in health care. These recommendations, categorized as subthemes, included the following: (1) designating spaces for daily and Friday prayer; (2) acknowledging Ramadan and Eid; (3) recognizing Muslim dietary needs; (4) creating a faith community liaison role; and (5) including religious identity in equity-focused and anti-discrimination programs and policies (see Table 2 for additional illustrative quotes).

3.1 | Muslim physicians struggled to maintain religious practices and observances due to unaccommodating organizational structures

Given the centrality of religion to their identity, participants sought to maintain religious practices such as ritual prayers and Ramadan

TABLE 2 Additional illustrative quotes.**Muslim physicians struggled to maintain religious practices and observances due to unaccommodating organizational structures**

Finding time to perform ritual prayers is hard

“The workday is crazy... “Hopefully I can pray on time today”, but I learned from experience that if I don't try to make it a priority, then I'll let the day escape me and then it'll never happen. It's on me to do it. No one's going to make it happen for me.” -South Asian, female, P115

“Usually, I have enough autonomy, and again, the patients are safe enough that I don't have to tell anyone. I could just go and do my own thing.”-South Asian, female, P303

Attending Friday prayer services is complicated

“Your supervisor is accommodating, but administration, is pushing them, like why is he taking two hours in the middle of the day? “We're at a busy time, and why are you letting him go on that?” Nobody came to me directly or told me anything, but my supervisor told me.”-South Asian, male, P69

“I could never make it (because of meetings) ...I told myself that I was like, “*Jumu'a* [Friday] prayer is not really mandatory for women, so I guess it's okay if I go to the meeting and not go to the prayer.”-South Asian, female, P303

Adjusting work schedules to accommodate Ramadan fasting is not easily done

“I have to explain every time...because our fast sometimes in the summer is not opening until 8:30, 9:00 pm, and the average dinner time is 6:00 pm for these official functions. So, that's hard to navigate.”-South Asian, female, P333

“It (my request for schedule adjustment) wouldn't be honored every single time, but I would always request the easier rotations around Ramadan, again, just to make sure that I'm not underperforming significantly at work but, at the same, just using whatever means I have to make it easy for myself.”-South Asian, male, P301

Islamic holidays are not formally recognized

“No, it wasn't (getting Eid off) something that was discussed. I worked on Eid. So, it was just...they don't sort of create a space or a safe space in which I can approach or talk about it, and then I don't know if they lack the knowledge to discuss it.”-Arab, male, P379

“When I was a first-year resident, I think I was put on a rotation during Eid. We're at a point where it's on my phone. Everyone knows. So, even if I don't say something, isn't it like Christmas? Shouldn't people know? But I didn't say anything.”-South Asian, female, P115

Muslim dietary needs are largely ignored by the workplace

“There's one thing which used to bother me, because they [religious scholars] say that you should not go where there is alcohol and all, but...I had to go to some of these departmental meetings and parties...It is for Allah to forgive me.” -South Asian, female, P245

Muslim physicians experienced religious discrimination which, in turn, impacted their professional trajectories and, at times, their personal well-being

Patients, colleagues, supervisors, and the institution, each, can discriminate against Muslim identity

Patients

“One of my colleagues, she went on maternity leave, I had to cover her patients and one of the guys - one of her patients refused to see me because I'm a Muslim.”-South Asian, female, P48

(Continues)

TABLE 2 (Continued)**Muslim physicians experienced religious discrimination which, in turn, impacted their professional trajectories and, at times, their personal well-being**

“So, if I walk in and I say my name is Dr. X, most people can't assume where I'm from but then I'll be like, “Oh yes, no, just call me (popular Muslim name),” and they'd be like, “Wow, you speak English so well,” and that - that one just hurts.”-Arab, male, P379

Colleagues

“Oh yes, we know you go pray,” and I was like, “How did you know?” He was like, “Oh, because so-and-so told us. Clearly, you're going every afternoon at a certain time period.” I knew that gentleman wasn't very friendly with me in residency anyways, so I could feel a little bit of that pull...So after that, I was only on that rotation for one month with him so I realized and I prayed at different times. I didn't want any backlash, I didn't want the program director to say anything even though I knew he was just one individual.”-South Asian, female, P303

“But I do get this sense from others that, especially like - it's just the questioning. It's just the, you know. I don't know. Some people questioned my abilities if I'm fasting as far as like taking care of patients and if I would be as sharp. I've had that happen a few times.”-Arab, female, P46

Supervisors

“The chair of our department and some others, we have seen that the way they would interact. So, I do sometimes feel that yes, that there is a little discrimination.”-South Asian, male, P71

“They changed every medical assistant that loved working with me. They would take the one that I got along with and I was so close to and they would give me the hardest one... in the span of five years, they've changed three medical assistants. Then they moved me from a practice to the other so I can build the other practice, and they gave me one that they did not allow me to talk to. ...I'm like, “How can a doctor work with a medical assistant that I cannot talk to?” “Maybe she's not comfortable talking to you?” I'm like, “What the heck? Why is she not comfortable? She doesn't even know me, we're completely new to each other. What is going on here?” “If you want to talk to her, you can talk to her through me,” that's the clinic manager. I'm like, “I've never heard of this before.”-Arab, female, P404

Institution

“My perception was that I was going to change the world but you just realize that there are a lot of roadblocks into what you want to do because of who you are and, because of this, you are not going to be their favorite and they have favoritism, especially in academic medicine, and it's just hard for you to - it's almost like they just make things very impossible for you.”-South Asian, female, P306

Religious discrimination negatively impacts physicians' careers, health, and religiosity

Career

“First, I really got averted from going to work and then I resigned. That's the work trajectory. The biggest impact of this is, I'm really questioning, do I want to be in the healthcare industry anymore, because it has impacted my personal life significantly.”-Arab, female, P404

(Continues)

TABLE 2 (Continued)

Muslim physicians experienced religious discrimination which, in turn, impacted their professional trajectories and, at times, their personal well-being

Health

"In light of what's happening in the Middle East. Everyone, myself, a couple of the other younger Muslim providers are worried. It's a fear. Nothing outright has been done to them but it's this idea of, "Are we all the enemy of each other?" So, there's a fear of speaking out because it might lead to being discriminated against or a change in a relationship."-South Asian, female, P115

"So, it does impact you, and I talk about that in my presentation, that being a Muslim physician, how that can be a cause of vicarious trauma and stress and can cause compassionate fatigue and burnout."-South Asian, female, P333

Religiosity

"I know another one of the residents here, she's Muslim. When she moved here too, I told her like, "What are you looking for?" She even told me she's [ignoring religious dietary guidelines] and she's like, "Yes, honestly, because the cafeteria only has these options, I end up eating it."-South Asian, female, P303

"It's like this is a difficult situation for me because do I miss the bonding experience outside of the hospital and just come off as a person who is uptight and doesn't want to befriend anybody or do I go against something that I personally have a moral problem with (attending events with alcohol)?"-Arab, male, P379

Participants were unsatisfied with institutional responses to their complaints of religious discrimination

"Eventually, I had to escalate it to my superiors who would explain that they would allow it (wear long sleeve shirt under scrubs or *hijab* in the OR) and to kind of leave me alone, but it didn't always stop and it was very person dependent."-Arab, female, P276

"I did try to address it with my supervisor a couple of times, but they would not directly get involved... when you're a faculty, and there's another faculty, there's a very fine line where you want anything permanent in your record versus their records."-South Asian, male, P69

Muslim Physicians Believed that Institutions could Implement Specific Educational and Policy Interventions to Advance the Religious Accommodations of Muslims in Healthcare

Designating spaces for daily and Friday prayer

"Main thing for me is having a physical place available in the hospital healthcare setting to offer *salah* (prayer) without any distractions, so I think that is the most important thing for me."-South Asian, male, P44

"It would be nice if they would accommodate like, "Okay, 1:00 to 2:00 on Fridays is known as the prayer session for the Muslims, so if they don't answer calls or pages in that time, please be aware that they might be occupied and they will answer..." That would be a nice accommodation."-South Asian, female, P303

Acknowledging Ramadan and Eid

"In Ramadan, being cognizant of the fasting. You still get the question, "Oh, you can't even drink water or drink coffee, right?" So, being cognizant of that at what fasting means, and taking

TABLE 2 (Continued)

Muslim Physicians Believed that Institutions could Implement Specific Educational and Policy Interventions to Advance the Religious Accommodations of Muslims in Healthcare

away harder assignments. If you're a student, you shouldn't have finals during that time, or if finals can be done after or something. The medical school is still trying to work that out."-South Asian, female, P333

"I think accommodations for Muslim obligations or holidays without question or without the provider needing to figure it out."-South Asian, female, P115

Recognizing Muslim dietary needs

"Food should be provided for the Muslims, and there should be distinction, because food is one of the big things, not that all Muslims eat halal food...I mean, even if, okay, not meat, but there should be other things available. They do, usually, nowadays. Even for vegetarians, they have accommodations."-South Asian, female, P245

"That they should be aware that these are our kind of concerns with the pork and with the alcohol...and perhaps they can make sure events don't have those things."-South Asian, male, P71

Creating a faith community liaison role

"I think empowering Muslims to know where the institutional policies are so they can advocate for themselves too. They should know as soon as they are employed somewhere who the point person is for these kinds of requests."-South Asian, female, P82

"I would include that there should be always a liaison. A liaison, one or two people that will represent the Muslim community or the Muslim physicians or the Muslim nurses or students that they will be a communicating liaison to see about the concerns, to share the concern."-Arab, male, P57

Including religious identity in equity-focused and anti-discrimination programs and policies

"Make sure we're treated equally, we're paid the same for the same work, and given the same benefits, and if people are promoted for certain reasons like merit, we should be promoted for those same reasons. That's my main thing."-South Asian, female, P48

"My hope would be that when you look at me-yes, being a Muslim is very important and integral. When I'm in a space that I'm seen as a professional, that every promotion, every job, and every grant is open too. I should have as much access to it like anybody else, but it's not assumed that I wouldn't be interested."-South Asian, female, P333

fasting, as well as observances of religious holidays, dress code, and dietary restrictions while at work. They used self-management strategies to do so and, less frequently, relied on assistance from peers and/or leadership. Here, we describe subthemes related to their struggles in maintaining religious practices and observances.

3.1.1 | Finding time to perform ritual prayers is hard

Most ($n = 14$) participants discreetly performed prayers during breaks and in off-the-path locations, for example, stairwells. Two received

support from their supervisors to secure both time and space to pray, while two were unable to consistently pray at work. Self-management was burdensome, as one participant mentioned, “If I get a break from 12:00 to 1:00 for lunch...I can go pray. Otherwise, I'll [struggle] to find time in the middle of a busy clinic.” (South Asian, male, P271). Another chose to “sneak out [because] it's really hard to build it into a schedule” (Arab, female, P404). Nearly half ($n = 8$) feared being judged by colleagues or administrators should they take prayer breaks. This challenge was more pronounced during training due to the power differential between trainees and supervisors. As one participant shared, “When I was a resident/medical student...I would not be vocal enough to say...I have to go pray” (South Asian, female, P115).

3.1.2 | Attending friday prayer services is complicated

Some ($n = 5$) male participants noted extreme challenges in fulfilling the religious obligation to perform Friday congregational prayers. They reported that patient care/clinical duties and the added stress of arranging schedule shifts without recourse to formal policies complicated the matter. Even when a few participants were able to secure accommodations, colleagues questioned their whereabouts, which made them anxious about additional scrutiny. As one participant stated, “My co-workers have questioned why I take a two-hour lunch break for Fridays, and then my manager has to give an explanation” (South Asian, male, P69). Physicians in training faced greater challenges. One participant shared the macroaggression he experienced, “I had to bring a letter from the mosque and give it to the dean...the dean was like, “No, you [must] get an exemption...This is medical school...You should be exempt in your religion (from Friday prayers while at work)” (South Asian, male, P44).

3.1.3 | Adjusting work schedules to accommodate Ramadan fasting is not easily done

As with prayer, most participants ($n = 13$) experienced little consideration for schedule adjustments during Ramadan (the month of dawn-to-dusk fasting from food and drink, and nightly prayer vigils). Only two received institutional support for flexible work hours. As a result, a few ($n = 3$) were unable to break their fasts on time. Institutional support, when elicited, was variable as noted by a participant, “I usually ask supervisors...This is going to be Ramadan, can you put me on an easier rotation? Some years it will happen; some years it doesn't” (South Asian, female, P306). Yet, another found her supervisors agreeable, noting, “I always request to not be put on call during Ramadan, and that's never been a problem” (Arab, female, P276). Again, participants experienced greater challenges as trainees. One mentioned, “I would still be operating during the start time (of the fast) and wouldn't be able to break the

fast until an hour later or if I was on call in the middle of the night and would be fasting, I would miss suhur (the pre-dawn meal...I would fast basically [a] 48-hour period”) (South Asian, male, P44).

3.1.4 | Islamic Holidays are Not Formally Recognized

Half of the participants ($n = 9$) noted their institutions did not recognize Islamic holidays (*Eid*). In addition, most ($n = 12$) had no institutional “cover” for getting the day off. This was perceived as inequitable as one participant commented, “I also worked Christmas for seven years, but I never had coverage for Eid” (Arab, female, P46). Two participants reported being unable to consistently take time off, two almost always had the holiday off, while the rest had variable experiences. Some participants ($n = 5$) switched workdays with colleagues, noting, “I'll cover my colleagues for Christmas or Jewish holidays and then they'll offer to cover for Eid” (South Asian, male, P271).

Here too physicians faced greater challenges during their training years. One described being at the whim of the program director, “If it was on a week(day), like Eid happens to fall on a Wednesday, I warn him ahead of time...Sometimes I would be able to [get off] and they would be accommodating and say, ‘Yes, have the morning off for prayer and then come in the afternoon.’ Other times they would say, ‘No, I'm really sorry. You're on an inpatient rotation. You have no choice; you have to show up” (South Asian, female, P303).

3.1.5 | Muslim dietary needs are largely ignored by the workplace

Most participants ($n = 11$) felt hospital administration did not take their dietary needs into account when planning events or meetings. One participant remarked, “I emailed our program administrator dietary restrictions and explained that half the group couldn't eat. So, they said, people can just bring their lunch from home if they can't eat it...They weren't creating an inclusive environment for us” (Arab, female, P46).

3.2 | Muslim physicians experienced religious discrimination, which, in turn, impacted their professional trajectories and, at times, their personal well-being

Many participants encountered discrimination directed at their religious identity from supervisors ($n = 9$), colleagues ($n = 12$), and patients ($n = 12$). Some attributed it to the overall institution. In response, most ($n = 11$) filed complaints or otherwise reported these instances. Deplorably, this unwelcoming climate took its toll on the professional and personal lives of participants ($n = 13$). Here, we describe the experiences and impacts of discrimination, along with participant responses.

3.2.1 | Patients, colleagues, supervisors, and the institution, each, can discriminate against Muslim identity

At the institutional level, participants interpreted actions and/or policies that overlooked physicians' religious needs and identity as discriminatory. Most ($n = 13$) worked in such climates. One lamented that there is "no system established for (countering) religious biases, or (providing anti-bias) training" (Arab, female, P404), while another noted this absence created a "glass ceiling effect" and the need to "work harder" to advance in his career (South Asian, male, P301).

From supervisors, religious discrimination was viewed by participants as being excluded from growth opportunities ($n = 7$), being passed over for promotion ($n = 7$), experiencing microaggressions ($n = 6$), and experiencing greater scrutiny ($n = 4$). One participant shared that despite her seniority, "I'm never considered [for a leadership role]. The administrative jobs still go to the White people?" (South Asian, female, P333).

From colleagues, participants experienced microaggressions ($n = 10$), were excluded from social activities ($n = 4$), and received added scrutiny regarding time away to perform religious practices ($n = 4$). One female physician reported being mistaken for "the Arabic interpreter" (South Asian, female, P286), while another dealt with "Muslim terrorist jokes saying that someone could mistake me as the Taliban or al-Qaida" (South Asian, male, P301).

From patients, a significant minority of participants experienced microaggressions ($n = 7$) or refused treatment ($n = 7$). Illustratively, one participant reported a patient saying, "How do I know you're not ISIS?" or "How do I know being a Muslim, you are really treating me...and not actually trying to harm me?" (South Asian, female, P333).

3.2.2 | Religious discrimination negatively impacts physicians' careers, health, and religiosity

Perceptions of discrimination and lack of accommodation influence clinical specialty choices ($n = 5$). Participants described some specialties as more difficult for practicing Muslims. As voiced by one participant, "Which specialty is it hard to take a day off or take 10 minutes to pray...that affected my specialty choice and then affected my job selection after residency" (Arab, female, P276).

Religious discrimination negatively impacted half of the participants' job satisfaction ($n = 9$), and some left their posts due to discrimination ($n = 6$). One participant described how the lack of advancement opportunities and a hostile culture contributed to her leaving the academy. She noted, "The reason I stayed here so long is I love what I do and it's very unique...I can both see patients as a clinician and do research...if they didn't treat me this way, I wouldn't have left, but after 15 years, I've had enough" (South Asian, female, P48).

Psychological impacts of discrimination included being fearful of revealing their religious identity ($n = 12$), stress ($n = 10$), and

depression and/or anxiety ($n = 10$). A participant said, "being Muslim, or a practicing Muslim, is going to impact [us] in some [negative] way" (Participant 286, South Asian, female). Another noted, "How many of us end up sustaining these microaggressions, and not talking about them, and not, therefore, doing anything about them. It's an emotionally difficult thing to do" (South Asian, female, P286). Additionally, participants reported emotional trauma due to a hostile environment that did not accommodate religious practices. One participant shared, "I was close to having a nervous breakdown with everything that they were doing to me" (South Asian, female, P48).

A sizeable minority of participants ($n = 6$) noted declinations in their intrinsic religiosity due to continually missing religious practices and observances, and/or having to constantly sublimate their religious identity. Some ($n = 7$) felt they had to actively change their commitment to Islam. Illustratively, one participant shared how her colleagues changed their religious practices at work, "I have friends who hide or just don't pray or fast at work, and they don't want people to know" (South Asian, female, P286). Another highlighted the long-lasting nature of such, "A lot of (medical) students who are practicing Muslims 'suffer silently' in terms of not being able to attend Jumu'a or pray, or I've noticed that they become non-practicing as a (result of) pressure from attendings (and) other faculty" (South Asian, male, P44).

3.2.3 | Participants were unsatisfied with institutional responses to their complaints of religious discrimination

Participants took both formal ($n = 11$) and informal ($n = 3$) actions to address religious discrimination, including reporting incidences to deans, human resources (HR), chief operating officers, department chairs, or other leaders. One filed a legal complaint with the U.S. Equal Employment Opportunity Commission after HR did not assist her. Yet, despite escalating the issues, participants felt unsatisfied with the ensuing responses ($n = 6$). As one participant shared, "I went to our university's dean of faculty affairs and I went to HR, and I was like, 'I feel like I'm being discriminated (against),' but no one did anything about it" (South Asian, female, P306). Participants who did not file formal complaints said they were dissuaded by the cumbersome process or feared repercussions.

3.3 | Muslim physicians believed that institutions could implement specific educational and policy interventions to advance the religious accommodation of Muslims in health care

Based on their experiences, and in order to meet their religious needs, participants offered multiple interventions that institutions could put in place and thereby advance religious accommodation. As noted below, many participants shared the same recommendations.

3.3.1 | Designating spaces for daily and Friday prayer

The most common religious accommodations suggested were designated spaces for prayer ($n = 16$) and policies that allowed individuals to take breaks to perform daily or Friday prayers ($n = 10$). As one participant said, “I think if they had policies in place where if a Muslim person asks for prayer, then [they say] ‘This is what we can do. This is a prayer space.’ I think that’s a much better position to have, a proactive position” (South Asian, male, P301). In particular, physicians in training should be allowed to attend religious services without fear of repercussion. In other words, their religious identity should not have to be “checked” at the hospital door.

3.3.2 | Acknowledging Ramadan and Eid

Some participants ($n = 10$) requested education and policy actions that increase supervisor awareness of the physical demands of fasting, as well as the importance of Islamic holidays to facilitate the accommodation of these observances. During Ramadan, one participant noted, “more arduous clinical duties can be reduced or off-loaded just during Ramadan to make that time a little easier” (Arab, female, P276). Concerning holidays another suggested, “Being aware ... and then asking me, ‘You know what, we scheduled you for Christmas. Are there any special days that you would like to take off?’” (Arab, male, P379).

3.3.3 | Recognizing Muslim Dietary Needs

Most participants ($n = 10$) advocated for accommodating Muslim dietary restrictions when work events were held. One recommended, “You need to take into account to have some halal or vegetarian options and not have pork products” (South Asian, female, P333).

3.3.4 | Creating a faith community liaison role

Many participants ($n = 9$) recommended a formal position be created that is responsible for assisting physicians, staff, and patients in securing religious accommodations. One participant shared, “I think that the first thing as a system that could be done is identifying who your population is...and asking them what it is they need, to identify what the holes are to fix” (South Asian, female, P115).

3.3.5 | Including religious identity in equity-focused and anti-discrimination programs and policies

Many participants felt that institutions overlooked the religious identity of the workforce. To address this situation, they suggested institutions collect data on the religious makeup of their workforce by asking employees to anonymously self-report religious affiliation

without tying such data to their employee record. In this way, individual privacy would be maintained while still allowing institutional leaders to begin equitably addressing the religious needs of their workforce. Additionally, formal ‘no tolerance’ policies that address anti-Muslim rhetoric from workers and patients were requested by some participants ($n = 5$).

4 | DISCUSSION

Our interviews with US Muslim physicians revealed multiple religious identity-based barriers to equity and inclusion in academic medicine. Maintaining religious practices (ritual prayers and Ramadan) and observances (religious holidays, dress code, and dietary restrictions) was challenging due to a lack of institutional awareness of these needs, as well as the absence of workplace policies to facilitate accommodation of these practices and observances. In the absence of existing policies and a proactive culture, clinicians often fended for themselves, which led to variability in being able to maintain their faith. The lack of structural accommodations also fueled feelings of being unsupported and psychological distress. During their training years, participants’ struggles were compounded as they felt unable to ask for accommodations for fear of being negatively assessed. For physicians in training, these early experiences of moral injury may have long-standing consequences.

Our findings of persistent religious discrimination and a lack of religious accommodation are unsettling but not shocking. Two decades after 9 out of 11, hostility, suspicion, and mistrust directed at Muslims pervades American society.² Portrayals of Muslims by political groups, news channels, and entertainment media are mostly negative. These images are transferred to the general public and reinforce anti-Muslim rhetoric, leading to an increase in hate crimes, fear, and prejudice.⁴¹ Our study reveals that Muslim clinicians are not spared from such experiences. Muslim physician practices and observances appear to not be well accommodated despite Title VII of the Civil Rights Act of 1964 requiring employers to reasonably accommodate an employee’s religious beliefs and practices so long as it does not cause undue hardship.

The added stress of fitting in their religious practices into overloaded workdays increased Muslim physicians’ sense of vulnerability and many reported feeling out of place, less apt to succeed, and targeted because of their religious identity. The resultant psychological ramifications of being fearful, anxious, or distressed, as well as the habituation to be less religiously practicing, are particularly alarming. Rather than being fulfilled by their careers, some Muslim physicians appeared to experience harm from the workplace. When added to the findings of increased job turnover on account of discrimination and prevalent lack of accommodation,²⁹ the profession should be concerned. If Muslim clinicians are crowded out of academic medicine or certain clinical specialties, health care equity is in jeopardy.

Relatedly, some participants shied away from seeking formal accommodations for fear of negative reprisals. Therefore, we recommend organizational leaders build cultures in which religious practices

and observances are respected. In particular, we call for creating flexible scheduling structures that allow Muslims to pray and fast. For example, one male participant worked a nontraditional schedule that allowed him time to attend Friday prayers. Another was allowed to switch clinical hours to accommodate Ramadan fasting. The recommendations provided by our interviewees would go a long way in advancing workplace equity by accommodating the religious needs of Muslim clinicians.

Our findings are consistent with studies linking perceived bias, microaggressions, and job-related stress with poorer health and well-being among physicians. Muslim women physicians already confront overlapping systems of inequities by virtue of their gender (e.g., earn less than men, slow progress to be promoted).⁸ Hence, discrimination related to their religious identity further compounds the harms of discrimination. Our findings are also consistent with studies that show workplace discrimination disproportionately affects physicians' career trajectories with greater effects among those in training.^{17,42,43} Our study adds to this literature by focusing on religious identity-directed discrimination and by delineating ways in which Muslim physicians' religious observances and practices are presently not, but can be, accommodated.

Our study is not without limitations. First, the sample was drawn from listservs of Muslim clinician organizations, introducing selection bias toward physicians with strong religious identities. Hence, it is likely that our sample is more religious than the general US Muslim physician population. Yet, given our interest in how religious identity intersects with workplace discrimination, the sample provides critical data. Second, we only included English-speaking participants because most US physicians have to be English literate to practice medicine, and because the additional time and costs associated with hiring staff to translate and analyze non-English data were prohibitive. Finally, our cohort was relatively small, and its demographic profile and experiences may not represent a comprehensive picture of Muslim clinician experiences. The fact that most participants were South Asian further detracts from generalizability. Nevertheless, thematic saturation was achieved with this modestly-sized participant pool, suggesting that our data are a valid representation of Muslim experiences. Additional research should focus on time trends related to discrimination and accommodation because it is possible that DEI efforts two decades ago had different effects than those instituted more recently, and that societal changes in anti-Muslim rhetoric may directly influence experiences in the health care workplace.

5 | CONCLUSION

Religious identity-based discrimination in the health care workplace, as well as a lack of accommodation of religious practices and observances, is common to the lived experiences of Muslim clinicians. Our data draw attention to the need for institutions to implement policies and programs to support the religious dimension of physicians' identity. Indeed, progress toward workforce diversity, equity, and inclusion requires that institutions create the conditions for physicians of all backgrounds to thrive.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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