SEPTEMBER 2012

REPORT

ISPU

A Window Into American Muslim Physicians:

CIVIC ENGAGEMENT AND COMMUNITY PARTICIPATION

THEIR DIVERSITY, CONTRIBUTIONS & CHALLENGES

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Institute *for* Social Policy *and* Understanding

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The Institute for Social Policy and Understanding (ISPU) sponsored this study to better understand core aspects of American Muslim Physicians (AMPs): their demographic profile, identity and values, civic and political engagement, and challenges with discrimination. This group, like American Muslims in general, is extremely diverse in terms of country of origin, ethnicity, and language. Our findings indicate that many of them are guided by their faith to practice medicine and to serve their community, local congregation, and humanitarian organizations. AMPs are similar to other American Muslims in their beliefs and adherence to religious practices. In terms of their support for civic engagement, they are comparable to their physician colleagues but lag behind in political participation. After 9/11, our participants, guided by their faith, assumed a stronger role as ambassadors of the Muslim community and sought to dispel misconceptions of Muslims and Islam. Discrimination based on religion, country of origin, and skin color continues to be an obstacle, particularly in the workplace. These findings provide valuable insight into their contributions both in and outside their profession. Designers of workplace anti-discrimination policies and cultural competency training guides would be well served by reaching out to these professionals and including their narratives. Subsequent research is needed to better appreciate how current immigration policies impact AMPs and the care for underserved Americans.

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REPORT

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Acknowledgements:

This research project has benefited from the time and contributions of many individuals. In particular, we would like to thank Dr. Hamada Hamid (ISPU Director at the Center for Global Health) for his invaluable instrumental support and time; Dr. Aneesa Nadir and Ms. Sana Malik for their help in conducting part of the interviews; and Dr. Soleman Abu Bader for his assistance in addressing statistical questions. In addition, we would like to acknowledge our research assistants: Ms. Susan Shafer, for her limitless efforts in data entry and reaching out to all Muslim and Arab organizations, as well as Ms. Tricia Moscato and Ms. Ashley Loetscher for their technical support. We would also like to thank all ISPU staff and colleagues, especially Dr. Iltefat Hamzavi, Khizer Husain, Siwar Bizri, Hiba Haque, Teeb Al-Samarrai, and Shireen Zaman, for their support at various stages of this project. This report would not have been possible without the generous initial support of the Association of Physicians of Pakistani descent of North America (APPNA) and additional support from The Islamic Medical Association of North America (IMANA).

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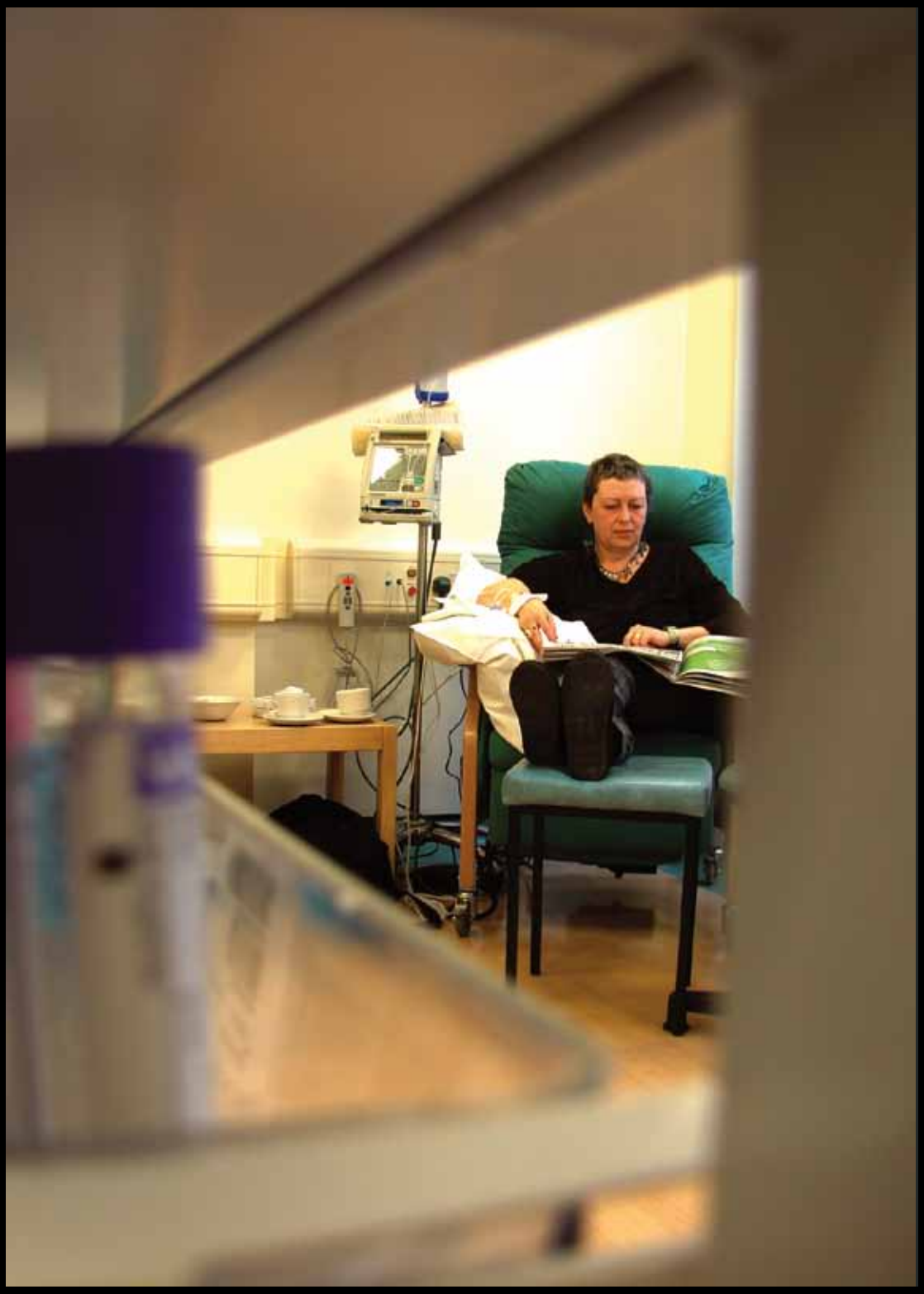


INTRODUCTION

The creation of Medicare and Medicaid in 1965 dramatically changed the availability of healthcare in the United States; however, it left a major gap in health services for Americans living in the inner-city and rural areas. The federal government sought to fill this gap by encouraging the immigration of international medical graduates (IMGs). By 1974, 20% of all American physicians were IMGs, as were 33% of all hospital resident trainees; by 2010, IMGs comprised 20% of the American physician workforce.[1] Many of them were practicing Muslims who also played an important role in building Islamic institutions in their adopted country.[2]

To date, no published studies deal specifically with American Muslim Physicians (AMPs). We have endeavored to study this sector based on the assumption that its members consist of influential people who are contributing to mainstream society and (in many cases) to their countries of origin.

There is a certain social responsibility, particularly on public health issues, that Americans generally assign to physicians.[3] Those who are knowledgeable about their communities, as well as about their patients' sociocultural needs and available health resources, often provide better patient care.[4] They may facilitate the procurement of appropriate health care for their patients, respond to the need for a more user-friendly health care system,[5] or speak to the public about health issues and inquiring about patients' social support systems.[6] Some scholars suggest that providing formal instruction on community involvement, both within and outside the classroom, could lead to higher community responsiveness among physicians and may help fill physician shortages in rural and other underserved areas.[7] A qualitative study of "community-responsive" advocate physicians indicates that they have knowledge of their own privilege and power, an understanding of "difference," exposure to marginalized groups, and the "motivation to do the right thing, give back, make a difference, and be intellectually challenged."[8]

In addition to their medical role, the AMPs' identity is shaped by their religion and, in many cases, their immigrant background. The role of religion in determining immigrants' identity has received increasing attention.[9] Numerous scholars have attempted to explain the increased role of religious identity and affiliation in the lives of post-1965 immigrants in the religiously pluralistic American society.[10] That said, faith-based discrimination, particularly in the wake of 9/11, has shaken the American Muslim community and brought new challenges.[11]

As the 2012 presidential election season moves into full swing, the American Muslim minority community has become a more important player on the political landscape, especially in key swing states.

Our primary objective in this study is to offer a first-of-its-kind portrait of AMPs: demographic characteristics, identity and values, civic and political engagement, and challenges with discrimination. From this research, we hope to start a conversation on how to reduce workplace discrimination, increase political participation, and better leverage this segment of the physician workforce to enhance cultural competency within the American healthcare system.

METHODS

This study used a mixed-methods research design utilizing both quantitative (surveys) and qualitative (individual interviews) research arms.

Muslim physicians were recruited to complete either a confidential on-line survey (SurveyMonkey©) or submit responses by mail. We received 543 completed surveys; however, twelve were excluded because of too many incomplete answers.

In the "Political Participation" and "Civic Engagement" sections, 100 participants did not answer all questions, dropped out, or skipped certain questions. To avoid skewing the data analysis, their surveys were discarded. Thus, analysis of these sections will reflect the sample's smaller size (431 instead of 531).

In-depth face-to-face interviews were also conducted with AMPs in New Jersey and Arizona. AMPs in each state were selected from a pool of survey participants who volunteered to take part in the individual interviews; additional participants were recruited through key Muslim leaders. Before the interview, all participants were briefed about the study describing the study's purpose, the type of questions to be asked, the risks and benefits, their rights as participants, and a consent form. Interviews commenced after they signed the consent form. In order to achieve greater geographical diversity, we also conducted 20 telephone interviews. Therefore, a total of 59 interviews with 62 individuals (20 in New Jersey, 22 in Arizona) were conducted; three married couples were interviewed together.

As the 2012 presidential election season moves into full swing, the American Muslim minority community has become a more important player on the political landscape, especially in key swing states.

KEY FINDINGS

The exact number of AMPs is not known; however, the number of Muslim physicians in the United States is estimated to be 50,000.[12] Since IMGs from the top twenty Muslim-majority countries number approximately 36,000, it is reasonable to assume at least 50,000 AMPs, given the number of non-immigrant Muslim physicians (in addition to immigrant Muslim physicians who do not come from the top 20 countries)[13] While Muslims comprise 1-2% of the American population, AMPs represent 5% of all American physicians. [14]

Survey participants were predominantly male (70%), married (87%), and, on average, forty-five years old (Table 1). Most identified as South Asian (46%) and Arab/Middle Eastern (33%), while 12% identified as East Asian, 5% as White/Caucasian, and 1% as West African. All but six of the participants were born and raised Muslim. More respondents were born in Pakistan (26%) than any other country—closely followed by United States/Canada at 19 percent.[15] Almost 33% of the AMPs captured in our survey live in Michigan, New Jersey, or Illinois.

Female respondents were, on average, more likely to have been born in the United States; and, if they had immigrated, were more likely to have done so at least fifteen years prior to their male counterparts. They also were younger (mean=40.6, SD=11.39) (mean=46.1, SD=12.84), more likely to have attended a medical school in this country, and less likely to be married than their male counterparts.

In contrast to the survey sample, the interview participants featured more women than men (35% vs. 22%) as well as a higher percentage of South Asians (56% vs. 46%). About 27% of the interviewees, versus 19% of the survey respondents, were born in the United States.

In both samples, almost 25% were graduates of American medical institutions (Table 1). A significant majority (80%) reported that they currently worked full-time, and 25% reported that they have been practicing for thirty years or more.

As the 2012 presidential election season moves into full swing, the American Muslim minority community has become a more important player on the political landscape, especially in key swing states.

Table 1: Demographic Characteristics of American Muslim Physician

Socio-Demographic Variables	Survey Sample (N=531(%)	Interview Sample (N=62(%))	No Response
GEOGRAPHIC AREAS			
Michigan	61 (11.5%)	2 (3.2%)	
New Jersey	54 (10.2%)	21(33.9%)	
Illinois	54 (10.2%)	1(1.6%)	
California	40 (7.5%)	1(1.6%)	
Texas	35 (6.6%)	23 (37.1%)	
New York	32 (6.2%)	00	
Ohio	28 (5.3%)	00	
Remaining 38 states	172 (42.3%)	14 (22.6%)	
GENDER			
Male	374 (70.4%)	40 (64.5%)	
Female	116 (23.7%)	22 (35.5%)	
AGE	MEAN=45.3 (SD=12.61)	MEAN=45	
<30	53 (10.3%)	3 (4.9%)	
31-40	166 (31.3%)	11 (17.7%)	
41-50	131 (24.7%)	24 (38.7%)	
51-60w	86 (16.2%)	19 (30.6%)	
61-82	80 (15.1%)	5 (8.1%)	
MARITAL STATUS			
Married	460 (86.6%)	56 (80.6%)	
Separated/Divorced/Widowed	24 (4.6%)	4 (9.4%)	
Single	40 (7.6%)	2	
NUMBER OF CHILDREN	MEAN=1.75 (SD=1.12)		
None		3 (4.8%)	
1-2	8 (1.5%)	26 (41.9%)	
3-4	209 (39.4%)	21(33.9%)	
5+	206 (38.8%)	3 (4.8%)	
No Answer	21 (4.0%)	10 (16.1%)	
ANNUAL INCOME			
Less than $100,000	80 (15.1%)		
$100,001–$150,000	49 (9.2%)		
$150,001–$200,000	65 (12.2%)		
$200,001–$250,000	62 (11.7%)		
$250,001–$300,000	61 (11.5%)		
More than $300,000	130 (24.5%)		
FINANCIAL SITUATION			N=60 (11.3%)
Poor	9 (1.7%)		
Fair	74 (13.9%)		
Good	234 (44.1%)		
Excellent	141 (26.6%)		
Don't know	13 (2.4%)		
PLACE OF BIRTH			
US/Canada	103 (19.4%)	17 (27.4%)	
Other countries	428 (80.6%)	45(72.6%)	
RACE/ETHNICITY			N=20(3.7%)
African American	2 (0.4%)		
Arab/Middle Eastern	176 (33.1%)	2 (3.2%)	
East Asian	63 (11.9%)	21 (33.9%)	
South Asian	242 (45.6%)	00	
White/Caucasian	25 (4.7%)	35 (56.5%)	
Other	3 (0.6%)	4 (6.4%)	

Socio-Demographic Variables	Survey Sample (N=531(%)	Interview Sample (N=62(%))	No Response
Country of Birth (35 countries)			
Egypt	39 (7.3%)	9 (14.5%)	
India	77 (14.5%)	7 (3.2%)	
Syria	55 (10.4 %)	5 (8.1%)	
Pakistan	139 (26.2 %)	21 (33.9%)	
Palestine/West Bank US/Canada	17 (3.2 %)	3 (4.8%)	
Other	103 (19.4%)	17 (27.4%)	
	101 (19 %)		
YEARS IN THE US	Mean=24.76 (SD=11.44)		N=114(21.5%)
1-15	102 (19.2%)	8 (12.9%)	
16-30	172 (32.4%)	30 (48.4%)	
31+	143 (26.9%)	24 (38.7%)	
CURRENT IMMIGRATION STATUS			N=96(18.5)
US citizen	359 (67.6%)	56 (90.3%)	
Green card	48 (9.1%)	5 (8.1%)	
Employment Visa	20 (3.8%)	1 (1.6%)	
Other	8 (1.5%)		
REASONS FOR COMING TO THE U.S.			N=98(15.8%)
Education Family	304 (57.3%)		
Economic	52 (9.8%)		
Political Conflict	43 (8.1%)		
Employment	16 (3.0%)		
Other	2 (0.4%)		
U.S. MEDICAL SCHOOL			N=63(11.9%)
Yes	147 (27.1%)	15 (24.2%)	
No	333 (61.3%)	47 (75.8%)	
EMPLOYMENT			N=66(12.4%)
Full-time	421 (77.5%)		
Part-time	35 (6.4%)		
Retired	11 (2.0%)		
Looking for employment	10 (1.9%)		
NUMBER OF HOURS/WEEK IN PATIENT CARE			N=114(21.5%)
<21	20 (4.4%)		
21-40	99 (21.7%)		
41-60	150 (32.9%)		
61+	73 (16.0%)		
MEDICAL PRACTICE SETTING			N=5(.09%)
Solo/2-person practice	139 (26.2%)		
Single/Multi-specialty group	118 (22.2%)		
University-Medical school	89 (16.8%)		
Hospital	74 (13.9%)		
Other	23 (4.3%)		
SETTING OF MEDICAL PRACTICE			N=87
Rural	36 (7.9%)		
Suburban	150 (32.9%)		
Urban	182 (39.9%)		
Rural/Suburban	1 (0.2%)		

Over 33% of the AMPs surveyed identified their specialty as internal medicine; 10% as pediatrics (Table 2); and another 20% cited surgery, family practice, cardiology, and anesthesiology.

Table 2: Medical Specialties of American Muslim Physicians, Surveys (N=531)

SPECIALTIES	n	%
Anesthesiology	19	3.6
Cardiology	29	5.5
Family Practice	22	4.1
Surgery	34	6.4
Internal Medicine	178	33.5
Pediatrics	57	10.7
All Other	189	35.6
No Response	3	0.6
Total	531	100

IDENTITY AND VALUES

Religion

About 84% of Muslim physicians surveyed identify and feel an affiliation with Islam (Table 3). Gallup's 2009 study of Muslim Americans reports that 80% view religion as important in their lives.[16] In a Medscape Physician Lifestyle Report 2012, 83% of physicians reported (n=29,025) that that they have a religious or spiritual belief, and slightly over 40% of them actively practice their faith.[17] In contrast, 78% of those in our survey report practicing and adhering to the laws and customs of Islam most or all of the time.

Specifically, many AMPs assigned a high level of importance to prayers (73%), charity (78%), fasting during Ramadan (73%), making the pilgrimage to Makka (73%), and to reading or listening to the Qur'an daily (63%).[18]

Table 3: Importance of Religious Activities among American Muslim Physicians Surveyed, N=531

	Never n (%)	Rarely n (%)	Sometimes n (%)	Most of the Time n (%)	All of the Time n (%)
In general, to what extent do you practice and adhere to the laws and customs of your religion?	7 (1.3%)	19 (3.6%)	65 (12.2%)	302 (56.9%)	112 (21.1%)
To what extent do you identify and feel affiliated with your religion?	5 (0.9%)	11 (2.1%)	40 (7.5%)	214 (40.3%)	233 (43.9%)
	Not At All Important n (%)	**Not Too Important n (%)**	**Somewhat Important n (%)**	**Very Important n (%)**	**Rather Not Answer or Missing n (%)**
Importance of Prayer	18 (3.4%)	22 (4.1%)	63 (11.9%)	326 (61.4%)	102 (19.3%)
Importance of giving Charity	4 (0.8%)	7 (1.3%)	45 (8.5%)	371 (69.9%)	104 (19.6%)
Importance of Fasting during Ramadan	18 (3.4%)	19 (3.6%)	32 (6.0%)	356 (67.0%)	106 (20.0%)
Importance of undertaking a pilgrimage to Mecca	23 (4.3%)	17 (3.2%)	60 (11.3%)	326 (61.4%)	105 (19.8%)
Importance of reading/listening to the Qur'an	35 (6.6%)	50 (9.4%)	141 (26.6%)	193 (36.3%)	112 (21.1%)

As the 2012 presidential election season moves into full swing, the American Muslim minority community has become a more important player on the political landscape, especially in key swing states.

Of our respondents, 50% reported that they attend a mosque at least once a week, and 49% stated that they were "somewhat" or "very" motivated by religion to practice medicine. In a study by Curlin et al., 46% of physicians (n=1,144) attend religious services twice or more per month, compared to 40% among the general American population.[19] These studies suggest that AMPs consider their faith just as important as their non-Muslim colleagues.

In the interviews, three key themes emerged: participants were proud of their Muslim identity, designated Islam as the basis of their professional values, and reported increasing their religious practice as young adults. Several reported that practicing a minority religion in the United States actually reinforced their religious identity, a trend in line with prior studies.[20] Various theories attempt to explain this often fluid phenomenon: religious identity and affiliation may provide material and social benefits, help to retain fidelity to one's culture of origin, and resolve conflicting ethnic and American identities. Alternatively, immigrants may find religion in this country more self-defining and meaningful as compared to that practiced in their country of birth. [21]

Culture and Family

Interviewees consistently emphasized cultural and family values. Supportive families were a significant part of AMPs' success stories. Several cited the hardship of leaving their parents or siblings behind and their efforts to remain connected to relatives by distributing income and seeking elders' advice in career decisions. Some relocated to be closer to aging parents, while others brought their parents here to live with them.

The support of spouses, both emotionally and in terms of shouldering domestic responsibilities—especially raising children—often emerged at two pivotal moments: during the physician's residency years and his/her choice of first practice site. Some spoke of repaying their spouses' generosity by supporting them financially, emotionally, offering medical assistance to extended family members, and taking domestic responsibility during a spouse's important career transition.

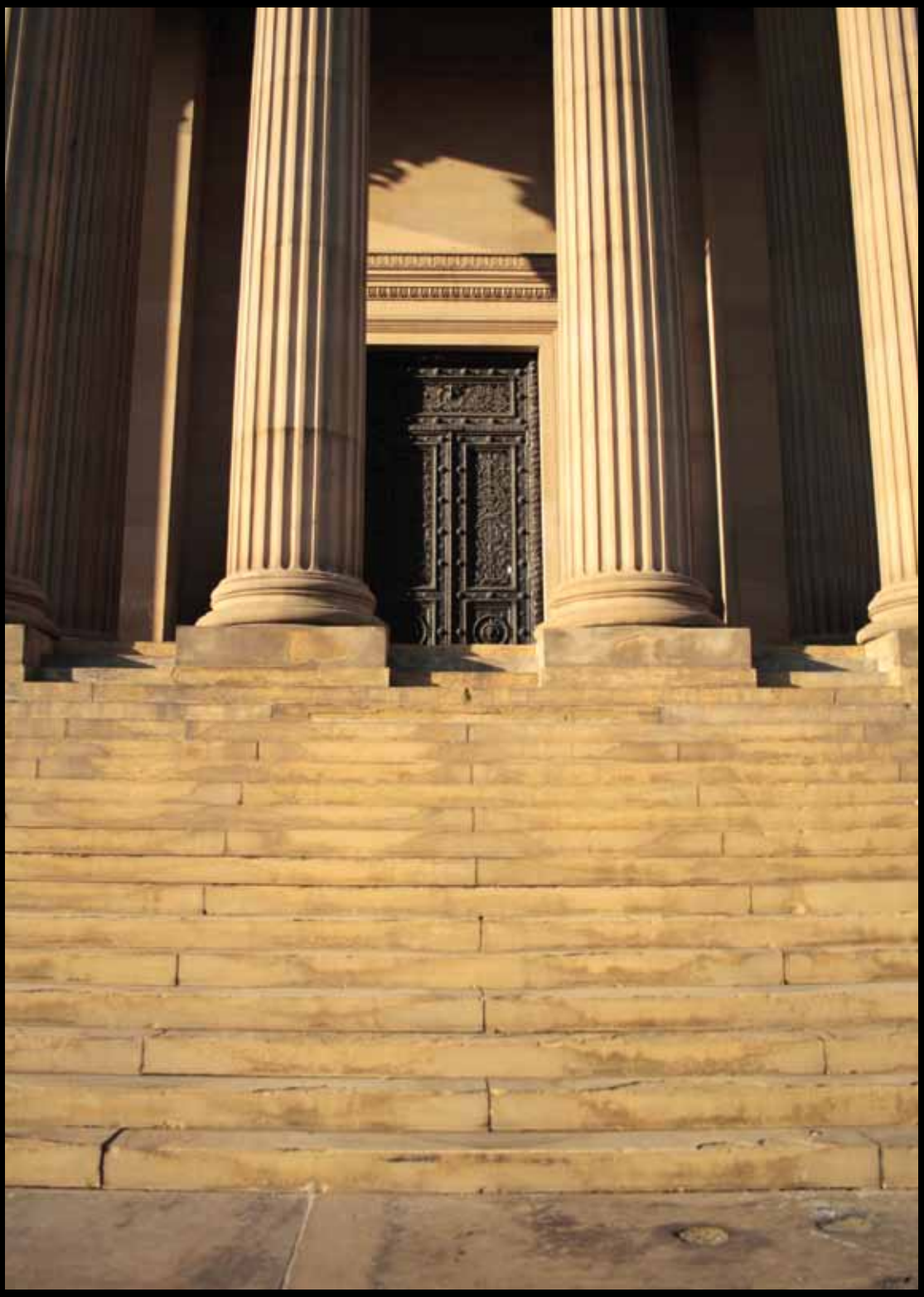
Involvement with children was stated as a high priority for the parents in our sample. Some lamented that their work schedule prevented their active involvement with their families; however, one respondent felt that his successful career was important as a model for his children.

Career decisions often involved compromises, like turning down fellowship opportunities for the sake of the family. Some explained that they chose a specialty that would allow more normal working hours so they could invest in family and community life. Several men spoke about prioritizing family time and being able to support their families. Despite the fact that both men and women stated common priorities and compromises between family and career, it was almost exclusively women who took a break from their careers to stay home with the children.

In sum, AMPs have sought to balance the demands of their professional and personal lives and to instill the value of hard work in their children. Women in particular have decided to take leaves in order to fulfill family obligations.

Values

Interviewees expressed a sense of responsibility to portray Muslims values (e.g., hard work, caring for others, and strict ethical behavior). They wish to share their faith and religious values with others, serve their local community and country, and live productive and peaceful lives. Many AMPs who chose to become active in their communities, even if only to eliminate negative perceptions of Islam, combined this with esteem for the "modern" value of achievement based on social standards, success, and motivating citizens to increase their social status. Their active endeavors to raise the status of Muslims in American society are evidence of the acquisition and incorporation of new values through acculturation and assimilation.



CIVIC ENGAGEMENT AND POLITICAL PARTICIPATION

The vast majority of physicians surveyed reported that it is "somewhat important" to "very important" for physicians to provide health-related expertise to local community organizations (93%), be politically involved in health-related matters (88%), and encourage medical organizations to advocate for the public's health (92%) (Table 4).[22] The majority of respondents indicated that it is "very important" for physicians to advocate for a variety of health issues ranging from reducing obesity (83%) to controlling guns (63%).

Table 4: Professional Attitudes of American Muslim Physicians (n=43123)

	Not at all important n (%)	Not very important n (%)	Somewhat important n (%)	Very Important n (%)	No Response
HOW IMPORTANT IS IT FOR PHYSICIANS TO:					
Provide health-related expertise to local community organizations?	5 (1.2%)	00	238 (55.2%)	163 (37.8%)	25 (5.8%)
Be politically involved in health-related matters at the local, state, or national level?	4 (0.9%)	26 (6.5%)	216 (50.1%)	161 (37.4%)	24 (5.6%)
Encourage medical organizations to advocate for the public's health?	8 (1.8%)	00	189 (43.9%)	208 (48.3%)	26 (6.0%)
HOW IMPORTANT IS IT THAT PHYSICIANS ADVOCATE FOR:					
Reduction in obesity and better nutrition	00	3 (0.7%)	45 (10.4%)	358 (83.1%)	25 (5.8%)
Prevention of teenage substance abuse	1 (0.2%)	7 (1.6%)	73 (16.9%)	323 (74.9%)	27 (6.3%)
Cultural responsiveness of health services in ethnically-diverse areas	2 (0.5%)	13 (3.0%)	111 (25.8%)	269 (62.4%)	36 (8.3%)
Tobacco Control	1 (0.2%)	5 (1.2%)	58 (13.5%)	339 (78.7%)	28 (6.5%)
Gun Control	12 (2.8%)	27 (6.3%)	94 (21.8%)	269 (62.4%)	29 (6.7%)

As the 2012 presidential election season moves into full swing, the American Muslim minority community has become a more important player on the political landscape, especially in key swing states.

When we asked whether or not they had been personally involved in the year prior to the study in civic activities, we noticed a gap between our participants' reported attitudes and actions. About 52% said they had volunteered their expertise; 21% had been politically active on a

local healthcare issue; and 31% had encouraged their professional society to address a public health or policy issue (Table 5). Nearly 59% had performed some community service in the last twelve months, and 33% reported being active in a civic organization.

Table 5: Health Activities of American Muslim Physicians (n=431)

IN THE PAST YEAR, HAVE YOU:	YES n (%)	NO n (%)	NO RESPONSE
provided care with no anticipation of reimbursement, in a setting serving poor and underserved patients?	318 (73.8%)	87 (20.2%)	26 (6.0%)
provided health-related expertise to local community organizations (e.g., school boards, parent-teacher organizations, athletic teams, and local media)?	224 (52.0%)	172 (39.9%)	35 (8.1%)
been politically active (other than voting) on a local health care issue?	92 (21.3%)	302 (70.1%)	37 (8.6%)
publicly advocated for universal health insurance coverage?	108 (25.1%)	288 (66.8%)	35 (8.1%)
encouraged your professional society to address a public health or policy issue that is not primarily concerned with physician welfare?	132 (30.6%)	261 (60.6%)	38 (8.8%)

The AMPs' opinions and actions regarding civic engagement are similar to those of their non-Muslim colleagues. According to a recent survey despite the strong support for community participation, less than 50% of American physicians volunteered with community organizations in the past year.[24] A physician study (n=1,662) found that while over 90% rated community participation, political involvement, and collective advocacy as "very important," only 66% of respondents had participated in at least one of these activities in the previous three years.

Regarding electoral activities, 33% of our respondents reported that they always vote in national and local elections, and about 38% reported donating money for candidates or political organizations (Table 6).

Table 6: Political Participation of American Muslim Physicians (n=431)

	ALWAYS N (%)	USUALLY N (%)	NEVER N (%)	NO RESPONSE
1. We know that most people don't vote in all elections. Do you vote in both national and local elections?	139 (32.3%)	183 (42.4%)	81 (18.8%)	28 (6.5%)
2. When there is an election taking place, do you try to convince people to vote for or against one of the parties or candidates, or not?	33 (7.7%)	149 (34.6%)	226 (52.4%)	23 (5.3%)
3. Do you wear a campaign button, put a sticker on your car, or place a sign in front of your house?	17 (3.9%)	56 (13%)	335 (77.7%)	23 (5.3%)
	YES, WITHIN THE LAST 12 MONTHS	**YES, BUT, NOT WITHIN THE LAST 12 MONTHS**	**NEVER**	**NO RESPONSE**
1. Have you volunteered for a political organization or candidate running for office?	50 (11.6%)	46 (10.7%)	319 (74%)	16 (3.7%)
2. Have you given money to a candidate, political party, or organization that supported candidates?	162 (37.6%)	80 (18.6%)	168 (39%)	21 (4.9%)

A survey done by the American College of Physician Executives (ACPE) of 766 physicians found that 71% had voted in every election and that 60% had donated money to candidates based on their stance on a particular healthcare policy.[25] In contrast, another study of physician voting patterns across four elections from 1996 to 2002 (n=1,274 physicians) found that their voting rate was 41.5%, 8.7% lower than that of the general public.[26] Still, AMPs seem to lag behind their physician colleagues in voting activity and in donating money to candidates. Interestingly, both our study and the ACPE research show that 50% of all physicians had personally met with their legislator to express an opinion (Table 7).

Table 7: Political Voice (n=431)

	YES, WITHIN THE LAST 12 MONTHS N (%)	YES, BUT NOT WITHIN THE LAST 12 MONTHS N (%)	NEVER N (%)	NO RESPONSE
1. Contacted or visited a public official – at any level of government – to express your opinion?	132 (30.6%)	86 (20.0%)	188 (43.6%)	25 (5.8%)
2. Contacted a newspaper or magazine to express your opinion on an issue?	59 (13.7%)	94 (21.8%)	230 (53.4%)	48 (11.1%)
3. Called in to a radio or television talk show to express your opinion on a political issue, even if you did not get on the air?	28 (6.5%)	74 (17.2%)	295 (68.4%)	34 (7.9%)
4. Signed an e-mail petition about a social or political issue?	131 (30.4%)	119 (27.6%)	153 (35.5%)	28 (6.5%)
5. Ever NOT bought something from a certain company because you disagree with the social or political values of the company that produces it?	164 (38.1%)	95 (22.0%)	137 (31.8%)	35 (8.1%)
6. Bought something because you like the social or political values of the company that produces or provides it?	183 (42.5%)	72 (16.7%)	141 (32.7%)	35 (8.1%)

Some of our interviewees described their civic engagement in various settings: attending town and school board meetings, participating in public health committees at the local level; supporting congressmen and -women, as well as legislators, at the state level; and supporting presidential candidates. Overall, most felt a responsibility to participate in the political process as citizens. One Muslim physician, who served on the ethics board of a New Jersey township because his city was plagued with corruption, stated: "I felt … that as a minority and as an American, we have to be involved … I don't think I would have done that before 9/11."

Another physician described a generational shift. Older immigrant Muslims had "stayed low" and tried to avoid problems, but now attitudes have changed:

The younger ones have more guts. They are more outspoken, and I admire them. I'm hoping my kids will be like that, to be like young Muslims who will speak for their problems back home and culture and don't be afraid from anything, because they are born here. So nobody can tell them "Go back to your country!"

In terms of political advocacy, some Muslim physicians see their role as informers of healthcare policy and are often driven by family circumstances. As one physician considered his aging parents, he commented on Medicare's financial problems, remarking that "it says a lot about a society who does not take care of their elderly … We are basically moving away from a value system that has made us strong as a nation." Another stated that becoming involved in mainstream public life has been a more gradual process: "I think I am more interested in what's happening here because I know I am going to bring up my kids here. I want to know what Barack Obama is doing with the healthcare system … I am not going to go back to Pakistan."

Muslim physicians' concerns about healthcare parallel those of other physicians. They feel caught up in the same system, one that they feel both constrains them and forces clinical decisions based not on clinical judgment, but rather on financial or bureaucratic concerns. Only five physicians interviewed described the present healthcare system as basically good or sound. Nearly two dozen others strongly supported general healthcare reform. They attribute excessive healthcare expenditures either to "defensive medicine" (e.g., ordering unnecessary tests and procedures in order to avoid malpractice litigation) or to hospitals or private practices trying to maximize financial reimbursement from insurance or out-of-pocket payers.[27]

Some AMPs lamented what they call the "perversion" of medicine from a health system to a business model, where the primary concern is for profit or financial solvency of the physician's practice, rather than what will serve patients' health. Like many other physicians, they also expressed frustration with bureaucratic paperwork, from insurance companies, government, or employer requirements. Others consider the lack of emphasis on preventive care measures through screening and health education as a major problem.[28]

Additionally, AMPs expressed problems with cross-cultural communication, particularly as it affects sensitivity to Muslim-specific issues (e.g., modesty and *halal* food and drugs) and sensitivity to immigrants' needs and concerns. A few expressed a desire for a greater incorporation or integration of holistic care or complementary and alternative medicine (CAM) practices into the mainstream health system.

In summary, AMPs in our study do not seem to differ drastically from other physicians in their support for and participation in civic organizations. But although they seem to have acquired a more invigorated sense of civic duty in recent years, their voting and participation in electoral activities lags behind that of their non-Muslim colleagues.

Serving Communities Here and Abroad

Many AMPs described their active involvement in ethnic, cultural, and religious professional organizations that offered charitable and humanitarian service opportunities. Over 70% of our survey respondents donate money to local or national charitable organizations, professional associations, and political or social groups. A total of 48.3% (n=262) had done free voluntary community service within the last 12 months. In terms of charitable work, 29.5% (n=160) reported walking, riding, or running for charitable causes, while 53.4% (n=290) reported helping to raise money for a charitable cause.

In the qualitative interviews, physicians mentioned the following major organizations as providing opportunities for charitable service: Egyptian American Professional Society; the Texas Asian Pakistani Physician Association, which organized a health fair for the community; the American Muslim Physicians from India, which seeks to operate clinics in India; the Pakistani Information Cultural Organization, which runs local food programs and charity events; and the National Arab-American Medical Association. Two participants mentioned offering training courses for the Syrian Arab Medical Society, making rounds at a hospital, and holding an annual conference for local physicians.

Many Muslim physicians felt that it was important, as Muslim physicians, to donate to charities, for "I think that it is part of the Muslim faith [to do so]." Several related this to giving zakat. Quite a few had also donated time or money to an institution or cause that did not reflect their ethnic or religious affiliations. In most of these cases, their charity took the form of providing medical attention regardless of insurance or ability to pay. Most of these Muslim physicians mentioned making sure to help people regardless of race, nationality, or religion. For example, one declared that "whether I'm helping a Christian, Jew, Hindu, Muslim, I don't care. If they really need you, help them." Another one said, "I donate [to] religious and nonreligious work[s] like to [the] Red Cross."

Many of our participants felt the need to “give back” to their countries of origin by donating money and time. A total of 39.3% (n=192) of survey respondents reported sending money to their families and relatives back home. About 62.1% (n=130) send up to $5,000 every year, 21.2% (n= 52) send between $5,000 and $10,000, and 17.2% (n=40) send $20,000 or more annually. Several interviewees mentioned traveling to their homelands to maintain family ties as well as to offer medical services and professional medical education with colleagues. They built clinics back home and supported tsunami victims in Indonesia and earthquake victims in Pakistan. As one said, “I pay my charity [in Egypt].” Others send money for education or attend fundraisers for relief efforts in Gaza, Pakistan, and elsewhere. Ethnic and religious medical organizations allow AMPs the opportunity to extend their professional involvement internationally.


FLIGHT

DISCRIMINATION – BEFORE & AFTER 9/11

During the interview sessions, we asked our participants about their experiences with feeling different and encountering discrimination. A few distinct themes emerged from their responses. AMPs reported experiencing more direct, personal discrimination from their own co-workers than from their patients. Some respondents described "indirect" discrimination from an increased atmosphere of hostility where religion, accent, skin color, or gender served as reasons for bias. Many characterized this prejudice as just one more obstacle to be overcome; by working hard to prove themselves, they had earned the respect of others over time. On the other hand, some felt that they were not subject to discrimination and reasoned that 9/11 offered new avenues for communication with other faith communities.

As the 2012 presidential election season moves into full swing, the American Muslim minority community has become a more important player on the political landscape, especially in key swing states.

Direct Discrimination

Most of these physicians linked everyday experiences of discrimination to a larger pattern of discrimination in social institutions: racism. The most common report alongside accent was skin color, particularly for those who were not white. In these cases, respondents felt they were at a disadvantage for belonging to a racial minority. In many cases they reported feeling discriminated against because of their names, especially when applying for jobs. Some said that their last names were the real test as to whether or not a patient would return or a potential employer would hire them.

A few others cited examples of institutional discrimination in their residency programs. One explained that the program administrators would purposefully fail foreign residents year after year so they would not progress. Another immigrant physician complained of how much more difficult it was to land a prestigious residency slot because of the preference for American graduates. One AMP complained that being foreign-trained creates the assumption that the patient will have to deal with cultural barriers. They noted that their accents became markers of being trained abroad and felt that this caused them to lose patients to other doctors. Furthermore, some AMPs feared that patients, particularly after 9/11, did not trust foreign doctors.

A few AMPs reported religious discrimination. One felt different for needing to leave meetings for prayer, experienced difficulties when fasting during Ramadan, and felt alienated by certain events such as the annual office Christmas party. Another complained about accusations of being "anti-Semitic" when he tried to help some Muslims at a local Muslim center. In many

cases, women felt or were even told by interviewers that they were afraid to hire a woman wearing a headscarf because it would scare away patients. One female physician talked about the intersection of gender and foreignness in her rejection by a patient: “First of all being a girl, female and being in a medical field, I’m a nurse until proved otherwise.”

One major theme that emerged in our interviews was a desire, especially after 9/11, to feel more—not less—religious and to exemplify good acts as ambassadors of Islam. They raised their profile in the community to help improve perceptions of Islam. “Now it’s, for better or worse after 9/11, everyone knows who we are … so I think we are more assertive.” One referred to 9/11 as a double-edged sword because, although the tragedy hurt many, it also provided Muslims with the chance to educate people about Islam. These physicians celebrated the American public’s increased interest in learning: “Now I think that Americans … they are more perceptive and welcoming, and more understanding.”

The notion of showing “real” or “true” Islam resonated with many of the physicians interviewed. They condemned terrorism in Sunday school at Islamic centers and joined interfaith speaker bureaus. Some mentioned the tremendous support they received from friends, family, neighbors, coworkers and patients in the days after 9/11. Interviewees said that “a lot of people went out of their way” to help or spoke of patients showing “care” or “concern” about their safety and that of their families. One Arizona physician even had patients make appointments just to let him know that they support him. Others said that neighbors, coworkers, and friends made comments like: “We know the Islam that we see in you” or “Please don’t be stressed over this. We know you. We know your family. We know that this has nothing to do with you or what you believe in or … your religion.”

Some physicians saw themselves as somewhat insulated from discrimination because of their profession. One speculated that professionals deal with less discrimination than unskilled immigrants, especially those who do not master the English language.

Indirect Discrimination

During interviews, some emphasized the effects of discrimination against the broader Muslim community rather than their direct experience of it. They spoke of a mosque being vandalized or overhearing loud comments directed against Muslims and Islam in general. A few spoke about feeling generally unsafe because of threats of retaliation against Muslims and post-

9/11 FBI interrogations. Such a sentiment echoes research from the Pew Center, which found that 53% of American Muslims say that it has become more difficult to be Muslim since 9/11 and that the government singles them out for increased surveillance.[29] The perceived double threat of foreign intelligence and domestic surveillance of immigrant Muslims compounds the alienation felt by many American Muslims.

Feelings of insecurity were more prevalent in public places, as physicians mentioned worrying about what fellow Americans were thinking of them. One spoke of being more anxious whenever she walks through a hospital lobby or the airport: "I wonder what this person is thinking about me." Another echoed: "I became very cautious. I wasn't sticking my neck out or giving my opinions freely … I became more reserved." At the same time, he expressed confidence in the United States' ability to "correct itself," citing the example of Obama's election as a hopeful sign.

AMPs spoke of "mistrust" and "pointing the fingers" because Muslims became publicly identified as "the bad people" due to 9/11. They pointed to the media and politicians as casting Muslims as an extremist monolith so that now "the [American] community at large looks at [Muslims] differently, making them "outsiders." One said that the "level of service" changed in places like the grocery store after 9/11, and another heard of a patient who demanded to see an American doctor, despite the fact that the Muslim physician *was* an American.

AMPs worried about losing their competitive edge in the job market, feeling unsafe in their communities, and losing patients because of 9/11. Some mentioned that other doctors were trying to steal patients by spreading rumors that AMPs support terrorism. One physician who was moving to rural Arizona after 9/11 said: "I was a little fearful and [a] little concerned … am I going to get this job all the way in a rural setting? Fortunately, everything turned out well, and people were 'very welcoming and nice.'" Her fears dissipated quickly.

Some spoke of Muslim patients "who were afraid to go and see … white physicians" because of 9/11, calling it "a trust issue." Another noted that many Muslims were "very skeptical, very scared of going to non-Muslim physicians, particularly those [patients] … whose immigration status is not very clear." He blamed the psychology of fear on himself, stating: "I think it's our own fears that we rationalize, not that non-Muslims are rejecting us; we are trying to read their mind with our fears, and that's what is causing the problem."

Some AMPs said that they did not feel the impact of 9/11: "I didn't have any difficulty" or "I, as a doctor or as a person, did not have any problem." Some *heard* of experiences of

discrimination and changes but did not "personally experience anything like that." Furthermore, they emphasized that they had no problems as doctors, but did not necessarily apply this to experiences outside the workplace. They did, however, believe that 9/11 has made them "more aware of the fact that we are Muslim."

The events of September 11th brought change to the lives of many American Muslims, including physicians. The findings of this study confirm this and also support previous studies that assert 9/11's negative and positive influences on the American Muslim community.[30] Those who felt more "secluded" or "alienated" after 9/11 reported that this event had had a more negative impact on their community. Many reported experiencing more discrimination in the workplace, in their personal lives, and in the community at large. These findings are consistent with previous studies that report increased rates of suspicion, hostility, hate crimes, and discrimination against Arab and Muslim Americans in the wake of 9/11,[31] and physicians were not exempt from this. Our findings indicate that many AMPs responded to this trauma with feelings of fear and loss of security, of losing their competitive edge in the job market, of feeling unsafe in their communities, and of losing patients.

For many AMPs, the most common change has been their greater public engagement and slightly increased religious involvement. Many of them sought some "visibility" and took advantage of 9/11 to construct a new positive meaning: using it as an educational opportunity for fellow Americans. These findings are supported by Zogby's 2004 poll, which indicates strong ethnic identity, even pride, in the face of adversity faced by the Arab and Muslim communities after 2001.[32] This response allowed participants to reflect on the causes of their fear and to advocate for new mechanisms that will ensure their safety. It also impelled many to further educate the American public about their culture; the meaning of Islam; and their community's needs, struggles, and concerns.

The qualitative interview data shows that Muslims often challenged the polarization of their identities, either "Muslim" or "American," by claiming both. Many AMPs have adopted the public role of "ambassadors for Islam" to counter negative stereotypes via their professional success and compassionate care provision, as well as through active engagement in interfaith events and speaking about Islam in their local communities.

Other scholars of Muslim life in the United States have suggested that this new religious ambassador role is part of a "disciplining effect" in American Muslim communities. By this, they mean that various state policies (e.g., surveillance of religious, political and charitable activities of Muslims; registration of foreign nationals from Muslim countries) have in a sense coerced American Muslims to articulate themselves as "good Muslims" and "loyal citizens" in opposition to the "bad Muslims" and "terrorists" who are the enemies.[33] Professor Sunaina Maira suggests that immigrant American Muslim youths have become adept at expressing their feeling of "belonging" (which she calls "cultural citizenship") in flexible and strategic ways in everyday life. Like the AMPs in our study, they see themselves as members of transnational Muslim and ethnic communities, as well as both loyal and dissenting citizens of the United States.[34] Those AMPs who frequently participate in transnational alumni associations, international medical relief and other humanitarian efforts, who transfer medical knowledge and technologies to their countries of origin, and who maintain family ties are often the same ones who engage in domestic debates on healthcare reform and support political campaigns.

Some scholars have suggested that the label "Muslim" has been "racialized" in the context of American society over the past several decades. Professor Nadine Naber, for instance, argues that Muslims in this country experience "cultural racism" and "nation-based racism," both of which are distinct. Cultural racism refers to "violence or harassment … justified on the basis that persons who were perceived to be 'Arab/Middle Eastern/Muslim' were rendered as inherently connected to a backward, inferior, and potentially threatening Arab culture, Muslim religion, or Arab Muslim civilization."[35] On the other hand, nation-based racism refers to the construction of particular immigrants as different from and inferior to whites based on the conception that "they" are foreign and thus embody a potentiality for criminality and/or immorality. Therefore, they must be "evicted, eliminated, or controlled."[36] She argues that the intersection of these two forms of racism result in the perception of American Muslims, particularly immigrant Muslims, as a moral, cultural, civilizational, *and* security threat in the context of the contemporary "war on terror." The respondents in our study articulated experiences of each, noting the intersection of their foreignness, Muslim-ness, and other markers of difference that others perceive as threateningly "other."

Limitations

Our sample was limited to those AMPs licensed to practice medicine in the United States and did not survey those IMGs who have not completed the licensing process and may therefore have different perceptions. Due to the snowball sampling methods, we may have an overrepresentation of Pakistani- and Indian-American physicians. In addition, our sample size was small and thus we could not evaluate whether there were statistically significant differences among AMPs based on geography, gender, racial/ethnic groups; between IMGs and AMPs who had attended American medical schools; or recent versus older graduates. Since we also relied on a snowball method, we may have a greater representation of Muslims who are well known to their community and, by inference, more engaged with it. There is also a potential for interview bias, as those interviewed may have been more reluctant to share personal information with the interviewer or their views are exaggerated.

DISCUSSION AND RECOMMENDATIONS

Our research has revealed a number of aspects related to AMPs' demographics and attitudes toward their successes and challenges. AMPs represent about 5% of all physicians licensed to practice in the United States. Our survey respondents were 70% male. Almost 50% were South Asian, and 33% were Arab/Middle Eastern. Only 25% were graduates of American medical schools. Our study showed that similar to other American Muslims, AMPs identified strongly with their faith or spiritual beliefs. They were significantly more adherent than non-Muslim physicians to their faith's practices and customs: 78% vs. 40%.[37] . Many AMPs in our study reported increasing their religious practice as young adults and often cited Islam as the basis for their professional values.

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AMPs track closely with other American physicians in their sense of social responsibility beyond the confines of their clinical practice (e.g., providing healthcare to uninsured patients, funding charity organizations, and advocating on public health issues in the community). As with other American physicians, however, there is a gap between their attitudes toward engagement and actual participation in community activities. In terms of political engagement, a smaller percentage of AMPs compared to other physicians vote in elections or donate to political candidates.

Before 9/11, our respondents felt discrimination through markers of "foreignness" such as last names, accents, headscarves, and/or skin color. After 9/11, the emerging environment of fear and guilt by association led AMPs to adopt a higher profile in their community via service and interfaith discussions, rather than abandoning association with Islam and fellow Muslims. Through this civic engagement, they reported that they now embraced both their American and Muslim identities more than they had before. Our study suggests that after 9/11 AMPs inspired by their faith stepped up their contribution as citizens by combating negative portrayals of Islam through talking about their faith and condemning terrorism and extremism. At the same time, however, the almost 20% of those surveyed who skipped questions related to religiosity or political engagement may also be emblematic of the vulnerability and wariness that American Muslims have in speaking openly about their religious or political views.

Furthermore, the anti-immigrant discourse and laws that have taken hold in Arizona, Georgia, and Alabama may further this sense of vulnerability, wariness, and alienation. Georgia's anti-immigrant legislation also includes new requirements, among them that all physicians must submit proof of citizenship or permanent residence status when applying for or renewing a

state medical license. This kind of legislation, while seemingly a mere bureaucratic hurdle for some, may actually discourage immigrant, foreign-born physicians from practicing and settling in these states. This is particularly challenging, given the shortage of physicians and healthcare professionals, especially in rural areas, faced by these very same states.[38]

We offer some recommendations below to not only better serve AMPs, but also to leverage their talents and heightened level of civic engagement to benefit all Americans. Muslim American physicians can be assets in a broad cultural competency framework. These recommendations pertain to three audiences: Muslim physician societies, national secular physician organizations, and health service organizations.

AMPs represent a diverse group of physicians who may be the ideal ambassadors of a healthcare delivery system that appreciates the patients' cultural context. Moreover, they may be more sensitive to the challenges of cross-cultural communication, thereby making healthcare more responsive and ultimately more effective. Making culturally competent healthcare more available depends upon two core elements: recruitment of minority providers and training in cultural awareness.

Increasing the diversity of medical professionals: This undertaking may help ensure the delivery of culturally competent care. AMPs understand the challenges of being a minority, both on a medical staff and in the larger community. They currently provide leadership in numerous free safety-net clinics and community health centers nationwide.

Beyond primary care, they can also work with residency programs and medical professional societies to boost minority representation in specialty care. AMPs need to play a greater role in such mainstream organizations as the American Medical Association (AMA) or the Association of American Medical Colleges (AAMC), inter alia, to help shape the mentoring and recruitment of the next generation of specialists.

Training fellow doctors and staff to increase cultural awareness: AMPs can play a role in designing national training guidelines that recognize the importance of curiosity, respect, and humility in each encounter, particularly with Muslim patients. Organizations such as the Islamic Networks Group (ING) have created training modules that AMPs can teach. While more training materials need to be developed, the real challenge is to reach the broadest possible

base of providers. To this end, AMPs need to work with the AMA and the AAMC to reach medical students and residents; and with the American College of Healthcare Executives to reach decision makers within medical education and the health system at large. Here, too, a link with the Department of Health and Human Services' Office of Minority Health is key, so that any official materials promoting cultural competency incorporate accurate Muslim narratives and perspectives.

Engage Muslim physicians and organizations in global health outreach: AMPs demonstrate significant motivation for and involvement in both domestic and international charitable health outreach and service programs. Individual physicians offer free care, and groups of Muslim physicians form free clinics. Many return to their birth countries to offer free or low-cost care and medical education in low-resource areas. An emerging trend is for AMPs, whether through ethnic organizations like APPNA or the National Arab American Medical Association or religiously based organizations like IMANA, to engage in domestic and international humanitarian relief activities. Policymakers could work to nurture such activities as part of global health diplomacy.

Recognize the internal diversity of the American Muslim community: Healthcare professionals and providers should be aware of the diversity of Muslim patients. According to a recent 2011 Pew Survey, 23% describe themselves as black, 21% as Asian, 6% as Hispanic, 19% as other or mixed, and 30% as white.[39] It is unclear if the community's racial and ethnic diversity produces AMPs who are more culturally sensitive to patients of other faiths or ethnicities. While several studies have noted that minority physicians provide the majority of care for underserved and minority patients, there is as yet no clear evidence that minority physicians provide more culturally sensitive care.[40] AMPs can help incorporate a broader range of narratives, one that includes the perspective of not only Muslim patients or providers, but also those of non-Muslim patients of diverse racial and ethnic backgrounds.

Conduct more research on workplace discrimination against AMPs in particular and IMGs in general: Workplace discrimination, whether by co-workers or patients, profoundly affects many AMPs. It is often difficult to tease out the various factors (e.g., religious, racial, gender, immigrant, and class identities) that contribute to such an experience. Future research is needed to ascertain the nature of discrimination in this particular professional group's workplace and what measures can be taken to sensitize residency program and other administrators and patients.

A FEW STEPS CAN BE TAKEN:

1. Encourage health systems administrators to provide a Muslim perspective in their sensitivity training programs: New-employee orientation and in-service training programs can make the medical staff more aware of the different forms of discrimination, its impact on their colleagues, and the consequences of deliberate insensitivity. AMPs should start with their own places of work to establish a culture that respects diversity. Patients should see the medical staff working in concert, regardless of faith, ethnicity, or race.

2. Encourage victims of discrimination to speak out: When a staff member is harassed, he/she should be empowered to report the incident without fear of reprisal. Managers need to take such incidents seriously and not just brush them off. By filing an official complaint, the administration can track its progress in providing a workplace environment that is as pleasant and professional as possible.

3. Evaluate the impact of anti-immigrant legislation and its potential repercussions on the recruitment and retention of AMPs and other immigrant health professionals: The potential impact of anti-immigrant legislation on the recruitment and retention of not only international medical graduates but also of American physicians with immigrant roots needs to be considered and evaluated.

CONCLUSION

Our study of AMPs is the first to capture this community in terms of its demographics, attitudes toward civic engagement, and political participation. Many immigrants who have established themselves professionally are playing leadership roles in building foundational Islamic institutions. They have sometimes faced discrimination at work and after 9/11 were subjected to the same indirect discrimination as others who looked Muslim or Middle Eastern. In response, they felt themselves driven by their faith to increase their participation in civic and interfaith activities. They have voiced their allegiances to both their Muslim and American identities. Still, many questions remain: How can AMPs play a larger role in advocating for health and other social issues? What are the barriers to political action? How can they lead other minorities into greater political participation? Our paper lays the foundation for future work on this important group of Muslim professionals.

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Endnotes

1 Ginzberg, 1982; Chen et al, 2010.

2 GhaneaBassiri, 2010; Abou El Fadl, 2001; Haddad 2011

3 Ginzberg, 1982

4 Steiner, Pathman, Jones, et. al., 1999

5 Witmer, Seifer, Finocchio, Leslie, & O'Neil, 1995

6 Steiner, Pathman, Jones et. al., 1999

7 Steiner, Pathman, Jones, et. al., 1999

8 Oandasan and Barker 2003

9 Ebaugh & Chafetz, 2000; Cadge and Ecklund, 2007

10 Peek, 2005

11 Lugo, & Stencel, 2007

12 Athar, 2004

13 American Medical Association Physician Masterfile. 2007.

14 Lugo, & Stencel, 2007; Sataline, 2010

15 Nine participants (1.7%) were born in Canada.

16 Gallup, 2009

17 WebMD, 2012

18 About 20% of the survey subjects did not answer these specific questions. We do not know exactly why these responses were omitted.

19 Curlin et al, 2005

20 Warner and Wittner, 1998; Williams, 1988

21 Peek 2005, 218-219.

22 For a more detailed examination on Muslim civic and political engagement, see Farid Senzai Engaging American Muslims: Political Trends and Attitudes (Washington DC: Institute for Social Policy and Understanding, 2012).

23 Smaller n (431 vs 531) is based on the 100 respondents who did not answer these questions. There were no obvious differences in terms of demographic factors between those who responded and those who did not.

24 Grande, & Armstrong 2008

25 Weimar, 2008

26 Grande et al, 2007

27 This issue has recently come to national prominence in the Choosing Wisely campaign, an initiative endorsed by a number of medical professional associations (http://choosingwisely.org).

28 Free access to preventive care services became a key component of the Affordable Care Act (2010).

29 Lugo, & Stencel, 2007

30 Abu-Ras & Abu-Bader, 2009; Abu-Ras, Gheith, & Courns, 2008; Akram, 2002; Bushman & Bonacci, 2004; Chand, Moghadam, 2004; Cainkar, 2004; Livengood & Stodolska, 2004; Moradi & Hasan, 2004

31 Abu-Ras & Abu-Bader, 2008 & 2009; Chand, Moghadam, 2004; ADC, 2003; International Civil Liberties Report, 2002; FBI, 2002 & 2006

32 “Muslims in the American Public Square” (Project MAPS) Georgetown/Zogby 2004.

33 Maira, 2008; Shryock, 2008.

34 Maira 2008

35 Nader, 2008, p. 280

36 Nader, 2008, p. 280.

37 WebMD 2012.

38 http://chronicle.augusta.com/news/health/2011-08-10/panel-suggests-cure-physician-shortage

39 Pew, 2011

40 Brotherton et al, 2000; Komaromy, 1996; Moy, & Bartman,1995

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