The Muslim WORLD
Constructing American Muslim Identity

Constructing American Muslim Identity: Tales of Two Clinics in Southern California

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The UMMA Community Clinic inhabits a small, flat-roofed building with stucco walls painted battleship gray. The name "University Muslim Medical Association" is prominently displayed alongside a crescent-star-family logo on the "Welcome — *Bienvenido*" signage in this densely populated South Central Los Angeles neighborhood. The clinic sits on a wide commercial street behind a black iron fence, the edges of its small parking lot neatly landscaped with palm trees, shrubs, and patches of green grass. The "annex" building, a modular unit in the parking lot, houses two Muslim administrative assistants and the CEO, Yasser Aman, whose Honda parked alongside has license plates reading, "ONE UMMA." The waiting room of the clinic is neat, clean, and generically clinical in appearance, the reception window providing a glimpse into a cramped room full of patient files. The white interior hallway, however, is lined with framed quotations from the Qurʾān and Sunnah, in Arabic with English translation. The staff room displays a prominent *Āyat al-Kursī* (*Verse of the Throne*), gold embroidered on black, like those often seen in traditional Muslim homes. The majority of UMMA clinic's governing board, however, is now non-Muslim,

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and all of the paid clinical staff, including the medical director, are non-Muslim.

In contrast, the stark white mobile unit with the green awning that houses Al-Shifa Clinic stands on the grounds of a mosque, Masjid Ulum, its parking lot dotted with palm trees, against the backdrop of rocky hills in the Muscoy section of San Bernardino. The mosque is home to a largely South Asian Muslim community in a predominantly Hispanic and African-American neighborhood. The mosque behind and the name *Al-Shifa*, Arabic for "healing," are the only markers inside or out that this clinic is a Muslim space. The sign out front reads, "Free Health Clinic for Everyone." In this organization, the board is entirely Muslim and the physician volunteers are nearly all Muslim, and yet the administrator, Mr. Saab, disclaimed repeatedly, "We do not mention Islam here."

The physical spaces of these two clinics provide the first indication to a client or observer of the ways in which each clinic manifests its Muslim identity. The geographic locations, the names of the clinics, and the adornment of interior spaces are held in tension with personnel and governance choices that demonstrate subtle differences in how Muslim identity is expressed and maintained in these organizations. In 2007, the authors interviewed leaders of ten Muslim community-based health organizations (MCBHOs) in four major metropolitan areas with large Muslim populations: Chicago, Detroit, Los Angeles, and Houston.[2] In this article, we focus on the role and expression of religious identity in the narrative accounts of these two Muslim clinics in the greater Los Angeles area: the University Muslim Medical Association Community Clinic, in Los Angeles (UMMA); and Al-Shifa Clinic in San Bernardino. Our analysis of the tales, the founding narratives of these new American Muslim charitable healthcare institutions, enables a grounded discussion of how clinic leaders are actively constructing the identity of these faith-based health service organizations and charting new paths for Muslims in American society.

Muslim community-based healthcare organizations (MCBHOs) first appeared in the U.S. in the early 1990s in Los Angeles, though most of the approximately 20 organizations have emerged in a range of North American cities during the past decade. We include in this category only organizations that provide ongoing professional physical or mental healthcare in their local communities *and* publicly identify their organizations as being Muslim, being led by Muslims, or having developed out of Muslim teachings or traditions. They include a range of groups, from domestic violence shelters and family counseling centers, to medical clinics and networks of private healthcare professionals. The organizations inhabit upper rooms, trailers, free-standing commercial buildings, renovated storefronts, or a virtual chain of private

offices. Taken together, they represent a significant form of Muslim participation in the American public square.

Most studies of the growth of Muslim communities in the United States have focused on the rapid progress of mosque-building, the emergence of Islamic schools, the formation of regional and continental organizations like the Islamic Society of North America and Islamic Circle of North America, and more recently, the emergence of Muslim political action groups. In assessing the historical development of these institutions, Schumann argues that "mainstream" immigrant and post-migrant Muslims in the United States constitute a "Muslim diaspora" that evolved an identity discourse in the 1980s–1990s that enables them to embrace political participation in the American public sphere while maintaining a sense of connection to the wider "Muslim world." He attributes the emergence of this discourse to "the universalistic desire to contribute Islamic values and norms to a wider notion of American civilization as well as to improve the situation of the Muslim community in the U.S. with lobbying and public relations work." Schumann thus depicts a U.S. Muslim diaspora in a "fateful triangle" of political communication between their own communities, the American public, and Muslims outside the U.S.[3]

American Muslims are also one religious community (or, perhaps more accurately, several communities of faith and practice sharing a body of tradition) among others in the United States. Studies of societal shifts in American religious groups identify a renewed spirit of voluntarism and increasing congregationalism.[4] They indicate a pluralism of organizational styles, decision-making processes, and interplays between individual piety, communal identity, service provision, and public religion.[5] The role of non-"church" religious organizations in the U.S. often complement, supplement, or challenge the religious practices within more official institutions.[6] In addition to documenting the rapid proliferation of mosques, Bagby and colleagues' Mosque Study notes the several different models of membership and governance, and a range of social services offered to members and neighborhood. They note that African-American mosques have a stronger tendency toward community service than their immigrant counterparts.[7] How might Muslim-initiated community services represent an integration of individual piety, communal identity, and public religion? How might these MCBHOs complement, supplement, or challenge official American Muslim institutions and the discourse of participation in American society?

With increasing governmental support for faith-based organizations in the provision of social services in the U.S. since the 1996 Welfare Reform Act, scholars of religion and constitutional law have devoted significant attention to the nexus of church-state relations these organizations represent.[8] Research on

the relationship between religion, spirituality, and health has also grown, though studies have focused mainly on the individual as the unit of analysis, rather than the institution. Important exceptions examine the role of African-American churches in mental health service and other health ministries.[9] The relative dearth of research on the role of religious identity in health organizations is surprising, as many major hospitals, nursing homes, free clinics, substance abuse facilities, and other organizations that address basic healthcare needs today were founded and influenced by religious people and organizations. In the nineteenth century, religion shaped the process of American hospital expansion, as Catholic and Jewish hospitals opened to accommodate patients and health practitioners who experienced mistreatment or exclusion from mainstream, predominantly Protestant institutions.[10] These religiously affiliated hospitals were open to everyone and, until the mid-twentieth century, cared for more than one quarter of all hospitalized patients.[11] The evolving religious values and shifting identities of these faith-based institutions continue to shape current administrative structures and social norms.[12]

Free healthcare clinics also have a particular history in the American healthcare landscape, first emerging in the mid-1960s in San Francisco (The Haight-Ashbury Free Clinic), Cleveland, Seattle, Cincinnati, Detroit, and other U.S. cities. Street clinics, neighborhood clinics, and youth clinics provided healthcare services to drug users, racial and ethnic minorities, youth, and others not well served by existing healthcare organizations. Though many clinics struggled to survive, they multiplied through subsequent decades, and there were an estimated 800 free clinics in operation in 2004. While many are completely secular in their origins and mission statements, many clinics are supported by religious leaders and volunteers, and some have close connections to local religious, particularly Christian, organizations.[13]

Many successful church-based programs develop into semi-autonomous religious service agencies, which can appeal both to religious donors, based on their values, motivations, and historical roots; and to secular donors, based on the quality of human services provided. Jeavons has developed a set of multidimensional criteria for evaluating the degree of religious or spiritual identity in faith-based organizations. He suggests that scholars examine the relevance of faith identity to an organization in its self-identity, the mix of participants, the sources and nature of its material resources, its products and their delivery, its decision-making, its distribution of power, and its primary partners within the organizational field.[14] Studies of faith-based social service organizations, however, note that they often struggle to maintain their religious identity as they deal with the growing pains of expanding services, hiring staff, and qualifying for public and private foundation funding.[15] In the current

climate of federal funding for faith-based social services, it is vital to consider the experience of minority religious organizations. Our study of Muslim clinics offers a unique window into the role of religious identity in faith-based service organizations and into the process of contemporary Muslim American identity formation.

Collecting and Analyzing the Clinic Narratives

During a field visit to the Los Angeles area in April 2007, the first author toured both clinic sites described above and conducted and recorded individual, semi-structured, in-depth interviews with three leaders of the UMMA clinic and two leaders of Al-Shifa clinic; and a group interview with five board members and the clinic manager of Al-Shifa. The second author subsequently conducted a telephone interview with a fourth leader of UMMA. Each hour-long interview explored the organization's history, relations with Muslim constituents, reasons for identifying as "Muslim," and lessons learned. Semi-structured interviews with multiple leaders of each organization were useful for eliciting multiple versions of the developmental narrative and perspectives on the identity of the organizations. We offered the option of anonymity for individual subjects, though all agreed to be identified. In addition to the interview data and field notes, we have examined in the analysis an eight-minute fundraising promotional DVD produced by UMMA.

Narrative analysis enables identification of common plot-lines between narrators, disruptions to these plots, and thematic connections within an individual's account and between accounts.[16] Since each of these interviews elicited stories of the development of the clinic and of personal involvement in the clinic, we have isolated narrative segments and applied narrative analysis techniques. A narrative approach helps to avoid the danger of selecting thematic statements out of context. Attending to the framework and structure, the often poetic repetitions and cadences, within even such mundane stories of groups gathering to sort out the logistics of running a medical clinic, we may present a fuller, more contextual social portrait of the organizations and their meanings for participants.

In order to examine organizing metaphors and structures that frame the meaning of participation in the clinic for these individuals, we re-transcribed selected accounts into poetic stanzas, breaking lines at critical junctures in meaning and shifts of vocal intonation.[17] Through repeated reading of each interview transcript, we isolated narrative segments of organizational development. After re-transcription of these segments, we assigned line numbers and summarized each stanza, outlining the thematic shifts and organizing metaphors in each account. We analyzed repeated patterns in the narrative segments from each narrator to determine the particular emphases,

concerns, and constructions of Muslim and religious identity in the overall account. We then juxtaposed the outlines and key segments to examine common emphases, concerns, and constructions, as well as divergences between the accounts. We also outlined the UMMA DVD narrative and analyzed it according to a similar scheme.

Narrative Plotlines

After analyzing the separate accounts of each narrator, we identified a common institutional narrative of each organization:

UMMA was initiated by second-generation (the majority of South Asian and some of Arab immigrant parents) medical students who were leaders of the progressive Muslim Student Association at UCLA. They originally envisioned a mobile van that would offer basic health screenings throughout impoverished South Central. The students received significant mentoring and organizational assistance from UCLA and Drew Schools of Medicine. LA city councilor Rita Walters helped them secure a building and federal funds to support the all-volunteer clinic for its first four years, 1996–2000. The founders reached a financial crisis point, at which time they held a highly successful fundraiser in the local Muslim community. They have since diversified their funding sources, including major public support through grants and limited billing, private foundation support, and a donor base of predominantly Muslim individuals. The clinic has expanded its specialty services and medical education programs, hired paid professional staff and reorganized its board of directors in order to be eligible for Federally Qualified Health Clinic status.

Al-Shifa Clinic began with a group of mid-career, mostly immigrant physicians from various hospitals and practices who prayed together on Fridays at Masjid Ulum. A Muslim county architect and Muslim county hospital cardiologist convinced the county to donate a used modular clinic for their use as a free clinic in an underserved neighborhood. These physicians raised funds in the Muslim community, secured permission to place the building on the grounds of the mosque, and received significant grants from the county government to open the clinic in 2000. Restrictions imposed by malpractice insurance policies limit the number of volunteers and hours of this half-time clinic, which has nevertheless expanded to include dental and eye clinics. The clinic is moving from primarily public sources to a Muslim donor base and private foundations for funding.

These developmental narratives have much in common. Each clinic was organized by a group of Muslim medical professionals who encountered each other in religious settings, whether on campus or in a mosque. Both groups saw a gap in primary health services for a large population of uninsured or underinsured populations in their local area. Both groups then utilized

connections to secular universities, hospitals, and local government in order to secure large donations of infrastructure and operational funding.

The narratives of both clinics present them as institutions that have an important educational mission for training and mentoring the next generation of health professionals. UMMA has striven from its inception (as the brainchild of medical students) to integrate its services with prominent local medical schools in order to train hundreds of medical students and residents in cross-cultural community medicine. Al-Shifa board members speak of the clinic as a "resource for the youth," where student volunteers can be exposed to "how medicine works" and can develop job skills. Board president Dr. Mohammed Aslam recounted that they had helped several students, at least one of them a Christian, get into medical school. Both clinics tout the fact that some residents choose to return as volunteers after their training.

The founding groups seem to have mobilized support from their local Muslim community at different points and in different ways. UMMA initially mobilized an existing informal network of Muslim medical students who were committed to volunteer, as did Al-Shifa. At the beginning of their project, Al-Shifa Clinic's founders approached the mosque director to acquire land and solicited donations from the Muslim community toward a county matching grant that would enable them to transport the building and open the clinic. UMMA CEO Yasser Aman confirms what the narrative suggests, that initially the founders "didn't really have a strategy of, 'Ok, let's make sure the Muslim community is invested.' " They focused on civic and community partnerships and turned to the local Muslim community for financial support at a later crisis point. UMMA narrators are very conscious, however, of the pride they now inspire in Muslims across the country and how significant the story of the "first Muslim clinic" has become.

The Al-Shifa Clinic continues to operate with an all-volunteer Muslim physician staff, and malpractice insurance policies emerge in their story as the significant barrier to expansion. While UMMA continues to use volunteer physicians, many of whom are Muslim, it has employed 16 non-Muslim staff to carry out its basic mission. Challenges that emerge in UMMA's narrative include maintaining the "volunteer spirit" and changing governance patterns to meet the mandates of public funders.

Organizing themes

The organizing theme for the narratives collected in this study is that these community-based health organizations are "Muslim," "local," "for everyone," and "in America." These themes emerge in a number of intersecting ways.

Muslim obligations to/in America.

The Al-Shifa developmental narratives begin with a group of physician friends who happen to be Muslim, "looking at opportunities to help people" (Khan 1.51–52). The intersection of professional, religious, and "American" motivations for community service is illustrated in a narrative from fellow board member, Dr. Mohammed Aslam, which we have entitled, "What we can do for our country" (Narrative 1.3–58):

You do your job
and take care of things
which have to be
and that's obviously
where we did start.
It was very interesting.
Obviously a lot of people were
thinking about this project
for some period of time
and my involvement
was basically that,
you know,
I always think about
what President Kennedy said:
"Ask what you can do
for your country,
not what your country
can do for you."
So when, thinking about
that one, that
we are physicians,
we are Muslims,
we happen to be
in this area.
And the United States is
the richest country,
but poorest in healthcare.
So this is a
perfect opportunity
which we can contribute
for this society
as a Muslim
and being present
over here,
people go
to all over the world,
missionaries,
yet there are a lot of
things to be done
right over here.
[True]
R: Perfect opportunity.
And to have the resources
to utilize the local resources
helped the people.
So that's what I think,
that's how we got started.

In this narrative, framed by "how we got started," Aslam, who appears to be in his late fifties, places his volunteer activities at the clinic late in his medical career. He has "done his job" and "taken care of things which have to be," fulfilled his basic obligations to complete an education, establish a career, and provide for his family. Aslam is well-established as a cardiologist in a supervisory role at the large county hospital. This job provides the foundation for his involvement in starting the clinic, which involved negotiating with the county's board of supervisors in order to secure the donation of the building. During the group interview, a member of the clinic's board joked that, when Aslam had performed a heart operation on one of the county supervisors, he had "put something in." The second stanza indicates

that he entered the clinic planning process after the initial group had developed the idea.

In the third stanza, Aslam links his personal involvement in Al-Shifa Clinic with Kennedy's famous patriotic call for Americans to engage in volunteer service. By so doing, he lays claim to an American icon and the spirit of volunteerism inherited from the 1960s that gave birth to both free clinics and the Peace Corps. The following three stanzas serve to deepen this sense of duty to country and to link it with his identity as Muslim. Stanza four includes three "we" statements, establishing the identity of the founders as physicians, Muslims, and local. In the fifth stanza, he states the underlying social issue to which the clinic is a patriotic response: though "your country" is seemingly the richest, it is "poorest in healthcare." Given this situation, the sixth stanza repeats the refrain of "we can contribute" (as physicians), "as a Muslim," and "over here" (local). The seventh stanza repeats the refrain "over here," contrasting the clinic's charitable mission with "missionaries" who "go all over the world." Dr. Talat Khan also compared her work for Al-Shifa to that of missionaries in South Asia, who "want to help people." Such comparisons may be important for narrators to establish Muslim charity work as part of normative mainstream religion in the United States.

The penultimate stanza provides a coda to the narrative. Aslam repeats the phrase "perfect opportunity," indicating that, as Muslim physicians who have fulfilled their obligations, they "have the resources" and can "utilize the local resources" to help "the people." The opportunity to fulfill one's obligations to one's country, to do your job in contributing "for this society as a Muslim," may resonate in amplified ways for immigrant professionals, who have adopted the United States as home. The repeated variations of the theme "being present over here" drives home the point of local loyalty and commitment, as opposed to involvement in "homeland" or foreign causes. This almost certainly reflects social pressure on immigrant Muslims in particular to justify and defend their Americanness by service to their country, imbuing the words of President Kennedy with an added layer of meaning. Notably, Kennedy's assassination had occurred two years prior to the Immigration Reform Act of 1965, under which a large wave of immigrant Muslim students and professionals from South Asia and the Middle East arrived.

External social forces have considerable weight in shaping the self-presentation of these American Muslim faith-based health organizations. Several narrators expressed their awareness that the clinic's work was representing "Muslims in general" (e.g., Board Narrative 7.72). A member of the Al-Shifa board narrates this sense in a segment we labeled, "The call to do something" (Board Narrative 2.19–45):

You know we always felt
obligated
to do something
for the community
and that was the main
motive behind it all.
Back then there was also
a lot of, unfortunately,
stigmatizing about the Muslim
community
being like either passive
or sometimes an offensive side,
a hostility issue
that was raised a lot
of times in the past,
and we thought the minimum
we can do
is to proceed and establish
a project like this one
and not only
to clean that image
but to actively get involved
in the community,
and maybe we can do
something good.

In the first and last stanzas of this passage, the board member provides the narrative frame: the obligation to "do something/something good" "for/in the community" was the fundamental motive for establishing the clinic. The middle stanzas, however, call attention to the external social forces. The second stanza refers to the stigma arising from the public impression that Muslims were "passive," uninvolved in the local public sphere, placing this stigma "back then," at the time of the clinic's founding. The third stanza, however, refers to the stigma of Muslim's offensiveness or hostility, a stigma that has assumed increasingly shrill tones in public discourse about Muslims in Western societies after 9/11. In the fourth stanza, then, the narrator proposes that the clinic is a rebuttal — though he suggests minimally — to both the "passive Muslim" and "hostile Muslim" images. In the final stanza, the clinic "cleans" the image of Muslims, who now "actively get involved in the community" and "do something good."

The UMMA Clinic leaders have assumed the mantle of "representing" Muslims in America with alacrity. The promotional DVD, "Healing Our Community," opens with the dramatic title, "As the nation watches . . .", then cuts to footage of the U.S. Congress. The title ". . . History unfolds in the House of Representatives," appears as Los Angeles' Representative Maxine Waters reads an official commendation for the UMMA Clinic in Congress

If you want to see
what Muslim Americans
truly represent,
go to the UMMA community clinic,
and you will see it there
(UMMA Video Narrative 1.1–12)

Dr. Munaf Kadri, a pediatrician and board member who became involved with the UMMA project before its opening, speaks about the initial motivation

for starting the project in a segment we have entitled, "Doing something for the community we're in" (Kadri 1.58–67, 86–94):

> and I think you know
> obviously I think
> it was probably
> because they were Muslim,
> it was much more part
> of the identity,
> you know, that hey,
> we as Muslims
> need to do something, too . . .
> So there was a definite feeling of
> "we as Muslims,"
> and I think these people
> had a good group,
> "we as Muslims
> need to do something
> We need to help the community."

The important refrain here is "we as Muslims need to do something," and throughout Kadri's narrative he emphasizes that "the community" which this group of Muslims are called to help is "the community we're in," because "we belong in this culture." (Kadri 1.29–147). This identification with the local community and as "American Muslims" is echoed in all of the UMMA narratives. For instance, Dr. Rumi Cader, UMMA's director of medical education whose younger brother founded the clinic, offers this coda in his opening narrative, "Muslims need to show we care" (Cader 1.91–102):

> The story of UMMA is basically,
> you know, one of uh
> hey, there's a need out there
> in underserved communities,
> we as American Muslims
> need to make a difference,
> we want to make a difference,
> we want to show
> that American Muslims care
> about our local folks
> that are not as,
> you know, well off

Cader summarizes the mission of UMMA as a response to the need of "underserved communities," who are "our local folks." He thereby lays claim to the South Central Los Angeles community of "not as . . . well off" people as his own. The identification with South Central Los Angeles is particularly strong in the UMMA video. Dr. Stock, a European-American physician volunteer, says that the clinic is located in "the exact spot where the LA riots happened," and founder Dr. Rushdi Cader continues:

> We found that
> this particular area,
> which was right on
> the same street
> where Reginald Denny was beaten
> during the civil disturbances
> of 1992,
> it's a place
> that had showed
> historic intolerance,
> and it should be
> a place that shows
> historic mercy
> and historic compassion.

In this brief passage, Rushdi Cader contrasts the image of violent streets, an infamous beating, and "historic intolerance" — reinforced on the video with visual images of police in riot gear — with the clinic image of "historic mercy and historic compassion." This latter phrase is significantly an allusion to the *basmala*, "In the Name of God, the Compassionate, the Merciful," the opening phrase for chapters of the Qurʾān and recited by pious Muslims when they initiate any new activity. Shirani points out that Rushdi Cader often used the phrase "civil disturbances" rather than "riots" in MSA magazine articles to describe the 1992 events, as a marker of political solidarity with progressive Third World and African-American student groups.[18] The UMMA Clinic narratives seem to locate their work very intentionally as Muslims in a specific place, as each stanza above emphasizes "particular area" and "place."

This background provides the context for interpreting Dr. Rumi Cader's extended narrative of the turn toward the local Muslim community during UMMA's financial crisis, which forms the final episode of the narrative we entitled, "Infancy and growing pains." After describing the dire financial situation in 2000, Cader continues,

And what we did was
we went out to
our Muslim population
here in Los Angeles county
and we got upward of I think
$350,000
and I'm probably underestimating
from a Muslim population,
right here in LA!
And the beauty of it was,
you know the Muslim
population
in general,
I think in most first world
countries,
there are a lot of immigrants
in the Muslim community
and the majority of charity
money that they give,
you know I'm from Sri Lanka,
it goes toward the local
orphanage in Sri Lanka,

and that's, generationally,
that has been a thing,
you know the Italian Americans
traditionally donate
to stuff out there.
But to make them aware
of a Muslim project
right here in their backdoor
and have people donating
people donating money to that
to a clinic where 98 plus
percent of the
patients are non-Muslims,
that's a statement.
That's showing Muslims care
not just the people in the clinic,
but the people
in the community too —
[The people funding it.]
R: Exactly, exactly
and that was a big thing for us
and we've always tried to keep
the Muslim identity of the clinic
and let Muslims know that,
hey this is a Muslim
organization
that's put together a clinic
to help people,
not just Muslims.

The narrative here is framed by stanzas that situate UMMA clearly within the local Muslim population of Los Angeles. The first stanza (268–276) stakes a claim to "our Muslim population," much like Cader claimed "our local folks" in the narrative discussed above. The repetition of "here in Los Angeles county" and "right here in LA!" in reference to the Muslim population adds emphasis to the claim of local belonging. The final stanza (318–324), with its fourfold use of "Muslim," puts the emphasis on the other end of this equation: the "Muslim identity" of the "Muslim organization," about which "Muslims" need to know. It returns, however, to the local: the goal of the clinic is to "help people, not just Muslims."

The second through forth stanzas (278–295) drive home both of these themes, while drawing a contrast with traditional immigrant patterns of charitable giving. Cader casts this event of tremendous local Muslim giving as an historic one, marking a generational shift in immigrant identity, similar to that of Italian Americans, to whom he alludes in lines 291–293. The second stanza (278–283) identifies "the Muslim population in general" as primarily immigrant minorities in the West ("in most first world countries"), thus locating himself in the center of a particular portion of the Muslim world. In the third and fourth stanzas (285–295), he compares his own experience of Sri Lankan Americans donating money toward "the local orphanage in Sri Lanka" to Italian Americans who "traditionally donate to stuff out there." In this verbal portrait, we see the shift that UMMA leaders would like to see in the Muslim community, a shift in the meaning of "local" as "out there" (295) to "right here" (276, 299). Other UMMA leaders offer similar analyses of previous generations of immigrant Muslims, being concerned with building "basic structures" like mosques and schools, such that "the message around a social service institution was just not really there yet" (Aman 2.29–31). UMMA is part of this generational shift in Muslim immigrant communities toward claiming an American identity by donating to local causes.

In the fifth stanza, Cader represents UMMA as an active agent of this shifting identity process. UMMA "make[s] them aware" of an opportunity to donate to "a Muslim project right here at their backdoor," contrasting the "right here" (299) with the "out there" of the previous stanza (295). UMMA raises awareness of the local within a traditionally homeland-focused immigrant Muslim community. Cader preserves some tension in this stanza, though, as the shift is not only away from donating to Muslim projects abroad but also away from projects that primarily benefit Muslims. Both of these shifts seem to be included in "that's a statement" (305).

UMMA's leaders consistently mention that 98% of their patient beneficiaries are non-Muslim, that they are "caring for those neighbors who are most

needy."[19] In Rumi Cader's sixth stanza, UMMA's representative function emerges clearly, as we hear echoes of the Congressional commendation in "That's showing Muslims care," including not just UMMA's staff, "but the people in the community, too" (307–310). Cader reiterates that this is important for UMMA, a "big thing" (316), to represent Muslims as caring for others.

This vision of accomplishing the shift in Muslim identity is reinforced with a coda in the final stanza Cader's narrative, as the "Muslim organization" creates a clinic "to help . . . not just Muslims." In UMMA's video, this message is reiterated by a chorus of voices. For instance, one board member, Li'i Futomoto, avers that "The Islamic message is bigger than just about us. It's bigger than just about giving to our own" (235–238). Rushdi Cader proclaims,

> UMMA has provided
> this remarkable setting
> of acceptance,
> of tolerance,
> of friendship,
> and of love (215–220)
>
> Islam is represented
> for what it is,
> which is an open-minded,
> tolerant faith. (230–233)

Such proclamations by leaders of Muslim faith-based service organizations are significant, as they are responding directly to external negative social forces that other FBOs may not face. These forces include discrimination and prejudice against both immigrants and Muslims in the United States, or forms of xenophobia and Islamophobia. As we have seen in the narratives examined in this section, the leaders of both clinics articulate the identity of their organization, and of themselves individually, in ways that emphasize their local community involvement *as* first- or second-generation immigrants as an *American* duty. They both also highlight the need to represent Muslims in a positive light, particularly as people who give generously, care for and serve non-Muslims.

Religious obligations to serve.

Thus far, we have treated Muslim identity in these clinics as a matter of responding to external social factors. Jeavons notes that an organization's name may have religious connotations, and its members may share religious convictions, but one must ask how relevant the name and religious convictions are for the mission of the organization. The participants may also share and articulate "core values" that are religious. He further suggests that scholars need to examine not only the products an organization delivers but also the manner in which these products are delivered, for instance, whether they are personally or impersonally delivered and whether they are mass-produced or relationship-promoting.[20]

The stated mission of both of these clinics is to provide high-quality, free or affordable healthcare for underserved communities. Whether this service is distinguishable from mainstream "secular" healthcare may depend on intangible factors. For instance, medical staff in the UMMA video claim to be "creating relationships" (161), offering a "setting of acceptance, tolerance, friendship and love" (215–220). Patients bear testimony that UMMA staff treat them like people instead of numbers, and that the clinic is "like a little piece of heaven in the middle of chaos" (170–172). Stories of personal transformation and compassion fill out the picture of how UMMA is "Healing Our Community" as a first step "to heal the world" (307). Several of the staff and storytellers who make these statements on the video are non-Muslim. Al-Shifa board members speak of feeling an extraordinary sense of conscientiousness about their work at the clinic, and of treating patients more humanely than at other clinics, or even at their own outside practices. Is the religious identity of the clinic or its staff germane, however, to the provision of compassionate care?

We have already seen that the "Muslim identity" of these organizations is significant for the secondary mission of each: to present a positive image of Muslims in American society. In this section, we examine some key narratives to discern internal forces that shape these Muslim faith-based clinics. Unlike mosques and PACs, these Muslim clinics demonstrate an Islamic identity not only for outsiders, but also for the participants and supporters themselves.

One emerging theme is that Muslims have a religious obligation to serve others. One narrator in the group interview with Al-Shifa Clinic's board developed the theme of "Discharging a Muslim obligation" (Board Narrative 7.41–61) as he described the founding of the clinic:

> Also many of us,
> and that comes back
> to the Muslim physician
> and the philosophy,
> all of us have
> the want to do charity
> and we don't expect
> thanks or, you know,
> gratitude for that.
>
> We think
> it's an obligation
> and we feel pride in that.
> So many of
> the physicians here
> feel guilt
> if they cannot come
> for any reason,
> they feel guilty.

The narrator speaks for the collective "we" in this passage. In the first stanza, he connects to his fellow board members as "many of us . . . Muslim physician[s]" who share a "philosophy." The second stanza elaborates on this philosophy, which includes a desire to "do charity" without expecting thanks.

The third and fourth stanza juxtapose the concepts of obligation and guilt. The common bond is reiterated in the final stanza, where the "many" are linked as physicians who may "feel guilty" if they cannot fulfill their Muslim obligation to serve at the clinic. Earlier in the interview, another narrator said, "the service to the underserved would be a form of worship . . . [It is] to your own benefit, to erase your bad deeds and shortcomings." Another added that Muslims needed to "establish that call," to devote "your work, also your effort, free of any return, free of any charge" (Board Narrative 2.60–64). For these narrators, Al-Shifa Clinic is a practical expression of their Muslim devotion, and represents a purification of motives for practicing medicine as a vocation.

In two UMMA sources, narrators expressed similar ideals for Muslim service. Dr. Altaf Kazi recalls being a part of the "idealistic group of students" with an idea but no resources, but "we had our Islamic faith in common, which compelled us to put our faith in action and provide services for a community in need" (Video 73–85). The following passage from the interview with Dr. Raziya Shaikh, UMMA's first clinic manager, illustrates this claim (Shaikh 4.1–33):

Uhm, well,
the bottom line was that . . .
the founders had seen
a need to serve the indigent —
medically indigent population
of Los Angeles,
and the underlying,
or the backdrop behind all of this
was the Muslim faith —
in Islam we were taught
that you're supposed to basically
serve the underserved
and provide them with the needs
that they're not provided with
and with the medical education
it just seemed like
a perfect fit
that you provide —
if you're being trained
in the medical sciences
it's a perfect fit —
you use your training
to help those who can't
afford medical care.
So that was the,
that was probably the ideology
behind starting a clinic.
I mean just at a very basic level
to help those in need.

Shaikh frames this portion of the narrative, like Kazi's comment above, with a discourse of "need," though the subject of the need in the first and last stanzas are different. In the first stanza, it is the "founders" of the clinic who have a "need to serve." In the final stanza, their "ideology" is "to help those in need." The second stanza locates Islam as the "underlying . . . backdrop" behind the Clinic, as Shaikh identifies the "Muslim faith," with a sense of obligation ("you're supposed to"), which Clinic founders "were taught." The presentation of binary opposites, "serve . . . underserved" and "provide . . . not

provided" adds emphasis to this sense of religious obligation. The terminology of underlying/backdrop/basically in this stanza is repeated in the final coda: "at a very basic level" (32). The next two stanzas link this religious mandate to "medical education." In both stanzas, she proclaims medical education/training as a "perfect fit" for fulfilling this obligation to "provide," then shifts the language to "help," which she repeats in the final line of the passage (33). Thus, in this narrative, Shaikh portrays Islam as nurturing a need . . . to help those in need, to serve the underserved, to provide what is not provided; and medical training as a perfect vehicle for doing so. Undoubtedly, the founders and volunteers in other faith-based health initiatives articulate their own religious motivations for service in similar ways to these Muslim providers.

Islam and decision-making.

When we ask Jeavons' question about how religious or spiritual information influences decision-making in the faith-based organization, some uniquely Muslim resources and issues come into play. The best illustration of this is a narrative from UMMA's Yasser Aman, which we have entitled "Being Faithful Muslim stewards" (4.1–202). Because of its length, we offer an abbreviated outline of each section:

1. *Zakāt*: "As a Muslim institution, . . . as the beneficiary of *zakāt* funds, we now have a trust." (9–14)
    a. Some discuss whether "people who receive that can be only Muslim recipients." (16–22)
    b. We want to "create a policy statement" about how UMMA will "handle certain donations that are very different from regular *sadaqa* donations." (24–32)
    c. We receive *zakāt* funds "from the Muslim community in general . . . from individuals" (36–58).
    d. "We need to educate our donors to let them know . . . how we're going to use it . . . [if they want it to be] available to everybody, then call it *sadaqa*; don't call it *zakāt*." (60–78)
    e. "We're on a fast track now . . . to strategize around that" (80–85)
2. *Ribā*: "The other thing as a Muslim institution [is] no interest in banking" (87–91)
    a. "We still hold true to the actual principles of financing" (93–99).
        1) "It may present challenges when we talk about capital campaigns . . . (101–105).
        2) "You can really make the argument [that UMMA clinic is] not a mosque . . . not a school [serving Muslims], . . . it's for others" (107–118).
    b. "We're trying to . . . get that information out from the experts" (120–123).
        1) We need to "see if [these policies] do apply or they don't" (125–129).
        2) There is the "Shura council . . . but there are some other economics folks" (131–149).
    c. We need "as an organization [to] come up with . . . our methodology . . . because there's no one mouthpiece [on *fiqh* issues]" (151–164).

d. "We were very careful when we were writing our bylaws" (169–177).
   1) "When we make decisions around what is a Muslim issue" (179–182).
   2) "The board shall make their decisions in line with the majority or the consensus of the Muslim community" (184–190).
   3) "We specifically didn't use the word scholar or *imam*" (192–197).
   4) "It gets very hairy when it comes to just how do you come up with a decision" (198–202).

Aman introduces sections 1 and 2 with the phrase, "as a Muslim institution." In an earlier narrative, by contrast, he had suggested that we "look at Umma as an institution, not necessarily religious, but it has its identity found in the Muslim community" (Aman 1.10–15). Here, Aman demonstrates that UMMA's Muslim identity means taking seriously the constraints imposed by the principles of Islamic economic jurisprudence concerning *zakāt* (obligatory charity, alms tax), *sadaqa* (charitable giving), and *ribā* (interest).

Zakāt is frequently discussed as the third of the five pillars of Islam, an annual act of worshipful giving required by God. The legal formula for *zakāt* on cash and precious metals is calculated at 2.5% of an individual's gross net income, after deducting family expenses. Dr. Muzammil Siddiqui, a nationally prominent American Muslim jurisprudent in Southern California who is mentioned in Aman's narrative, declared in a popular published sermon that "*Zakāt* is also to help the needy Muslims only. Non-Muslims can be helped from *Sadaqat* [*sadaqa*] and other charities."[21] *Sadaqa* is a broader term for voluntary charity, and may include a range of activities, from offering a smile to general charitable giving and forms of public service. *Ribā* is a financial practice prohibited in Islamic law. It is alternately defined narrowly as usury, prohibiting the excessive accumulation of wealth at the expense of another; or as simple interest, thus prohibiting most forms of banking and finance common in Western capitalist societies. Muslim financial institutions and organizations have designed *ribā*-free mortgages and profit-sharing cooperative investment plans to avoid engaging in the interest economy.

Returning to Aman's narrative, we can see a reflection of the debate and its effect on UMMA as a "Muslim institution." Each section of the "Being faithful Muslim stewards" narrative ends with unresolved tension, as the organization is "trying to strategize" (4.80–85) or finds the situation "hairy when it comes to just how do you come up with a decision" (4.198–202). The first section focuses on the use of *zakāt* funds, which UMMA receives from individual donors. Aman questions Siddiqui's restriction of *zakāt* beneficiaries to Muslims ("no one mouthpiece"), which would certainly be difficult to monitor in a clinic that serves 98% non-Muslim patients. He nevertheless suggests that "we need to educate our donors . . . this is how we're going to use it . . . call it *sadaqa*, don't call it *zakāt*" (4.63–78). The need to "create a policy," "figure

that out," and "strategize" reflects significant scholarly and lay debates about the principles of *zakāt* and the proper methods for its collection and distribution that are frequent in contemporary Muslim diaspora communities.

In the second section on *ribā*, which Aman defines as "no interest in banking" (91), he characterizes this as something that may come up in the future, as UMMA expands and runs capital campaigns. He states, in "Being faithful Muslim stewards" (4.93–99):

> you know, even though
> the majority of our funds
> are not from the
> Muslim community,
> we still hold true
> to the actual principles
> of financing.

In this stanza, Aman qualifies his statement about UMMA belonging within the Muslim community with "even though . . . we still." He returns to this in the stanzas immediately following these (107–149), with the hypothetical "argument" that, whereas Islamic schools and mosques may be bound by such Islamic finance principles, UMMA clinic may be exempt, because it serves the general public.

The final section of this narrative, lines 169–202, outline the current strategy that UMMA has in place to remain faithful to Islamic economic jurisprudence. Aman says that, before they brought in non-Muslim board members, the founders wrote by-laws that state, in carefully chosen language (Aman 4.179–202),

> when we make decisions
> around what is a Muslim issue
> and a non, it that —
> and we chose a language
> that the board shall strive to,
> the wording is really,
> the board shall
> make their decisions
> in line with the majority
> or the consensus of
> the Muslim community.
> We specifically didn't use
> the word scholar or imam
> or anything like that
> because any board
> 10, 15, 20 years ago [*sic*]
> can — it's just like today,
> so it gets very hairy
> when it comes to just
> how do you come up
> with a decision.

Here, the first, second and fourth stanzas repeat the framing phrase, "make" or "come up with" a "decision." The terms "language" and "word" recur in the first three stanzas, coupled with Aman's hesitating speech (181, 185), indicates the delicate nature of the issue at hand. The "Muslim issue" of the first stanza is parallel to "the majority or consensus of the Muslim community" in the third, and the latter is deliberately contrasted in the fourth

stanza with "scholar or imam." In traditional Sunni Muslim jurisprudence, the concept of "consensus of the community" (*ijma'*) as a source of law is often interpreted as a consensus among qualified scholars of *fiqh*. This section of Aman's narrative reveals two important positions: first, that he sees contemporary American Islamic legal authority as disputed and in flux ("years ago . . . just like today"); second, that the predominantly non-Muslim board of the clinic must abide by the current understanding of "Muslim issues" such as *zakāt*, *sadaqa*, and *ribā* in making its financial decisions. Though it remains "hairy" and not fully worked out, UMMA as an organization clearly takes into account religious and spiritual information as a part of its decision-making processes.

One interesting part of UMMA's story, however, is how it is striving to maintain this Muslim identity as it has grown and adapted. The people making decisions on the board are now predominantly non-Muslim, and the paid clinic staff is completely non-Muslim. The executive staff and many volunteers are Muslims, but many non-Muslim students and physicians also volunteer. In Kadri's and Aman's narratives of the clinic's development, they mention two factors that account for this shift from an originally all-Muslim staff and volunteer base. Aman attributes the change to a need to be relevant to the community being served. He emphasizes in his opening narrative that the founders did not see themselves as doing something *for* the community, but rather *with* the community, in a partnership (Aman 1.17–32). Subsequently, they recognized a need to employ staff who could speak Spanish and who "understood our community better." The clinic decided to expand their staff significantly in 2005–2006, resulting in "the majority of our staff [being] not from the Muslim community." (Aman 2.99–114). Kadri explains the shifting make-up of the governing board in an extended passage, which we have entitled, "Muslim identity markers," abbreviated below:

> In order for us to get the money, to become . . . a Federally Qualified Health Clinic . . . our board used to be predominantly Muslim before, . . . we have to change the dynamics of the board . . . The people that started UMMA were not on the board anymore, a few people switched to advisory status, . . . and our board has changed . . . We had to get other people from outside of it . . . the majority of them have to be [local] community members . . . We're not a Muslim board, I would say, overwhelmingly, at all . . . It was mandated . . . It's been very difficult [to find Muslim board members, because] they have to be living in that community.
>
> We try to do prayers before we start rounds, in our meeting, so that we establish our identity in a similar way that other [faith-based] hospitals

> do . . . And I think we're much more conscientious now of that than we were before. Now we have the translation of the *surah*, you know the *al-hamdulillah*, which is just 'in the name of God' to begin, . . . And we will have a translation when we end our session, too. And I think they're aware . . . that we'll go off to prayers in the middle of our talk or if we're having a meeting, [to perform] the prayer of the sunset . . .
>
> If you go to UMMA, it would be nice to see women who are covered who are working in the front, so people would realize these are Muslim people and not everybody is awful and trying to do awful things. But we have non-Muslim office workers. I mean, it's hard enough getting nurses or MAs [medical assistants]. I mean it's, like, the reality of life. (Kadri 4.1–162)

This narrative is a poignant reminder of the ways in which faith-based organizations evolve in response to their own success as service institutions and in response to the demands of funding agencies. In this case, the federal program that is designed to support community clinics, through subsidizing prescription drug purchases and medical training staff, "mandated" changes in the composition and dynamics of the organization's governing board. Whereas Aman's narrative depicts UMMA's staffing decisions as pragmatic adjustment to the linguistic and cultural environment in which the Clinic functions, Kadri laments the difficulty in finding community-based Muslim board members and the loss of the Clinic's founders on the board. He also refers to the changes in staff composition, alluding again to UMMA's secondary but important mission: "so people would realize these are Muslim people and not everybody is awful and trying to do awful things" (Kadri 4.151–155).

Kadri's narrative likewise points to ways in which the organization tries to preserve its Muslim identity in the face of such external forces. The use of translated phrases of Muslim piety and Qur'ān verses at the beginning of meetings, as well as the regular interruption of meetings for ritual prayer (*salah*), are reminders of the Muslim-ness of the organization. These rituals, along with the physical embellishment of the walls of the Clinic with Arabic calligraphy and translations of Qur'ān and *hadith*, are efforts to maintain an environment that, as Aman says, "remind[s] people of the background" of the organization (Aman 2.128–129).

Conclusion

These narratives illuminate the dynamic interplay of important aspects of Muslim identity for these two clinics as faith-based service organizations. Both Al-Shifa and UMMA clinics represent for their members an important claim of Muslim immigrants on American identity and local belonging. The leaders present themselves (or perhaps *perform their selves*) as fulfilling a

religious obligation, purifying their motives for professional care provision, and representing Islam and the broader Muslim community in a public square where the stigmatization of Islam has taken a personal and a communal toll. These performative claims of identity constitute a refusal to accept an external self-definition.[22]

Dr. Aslam of Al-Shifa Clinic interprets the emergence of Muslim community-based health organizations in this way:

> I think Muslim people feel that their participation in the local communities, to help the local communities, is also important. Not to remain isolated, [but] to become part of the mainstream — and I think this is — you'll have to come with something. When somebody invites you to come to a party, you have to bring something.[23]

These Muslim faith-based clinics are the dish that American Muslims are bringing to the party of U.S. healthcare services. There is nothing particularly exotic about the shape of the dish or its contents. The founders and volunteers share with those in other mainstream faith-based community clinics a combined sense of religious and professional vocation to care for the needy neighbor. Like other faith-based organizations, they mobilize resources that are within their sphere of influence, and these include religious entities and individuals as well as academic and governmental resources, to accomplish their primary mission. The effects of growth in services and increasing reliance on public and private funding sources, as illustrated by UMMA's adjustment to the FQHC standards, may be shared by many FBOs. The difficulty of finding appropriate community members of a governing board who also share the religious affiliation of the organization is likely less of a problem for Catholic and Protestant FBOs than it is for religious minority groups. The particular concerns of Muslim clinics about religiously appropriate financial decision-making may set them apart from many Christian organizations, though it is possible that some Jewish faith-based organizations might share similar concerns.

What does set these Muslim clinics apart is how public the presentation of the dish might be at the party. The public sphere in which Muslim FBOs operate is much more highly charged than for most other religious groups. The secondary purpose of these organizations — to present a positive image of American Muslims as a compassionate, generous, local healing presence — provides a unique motivation and shapes organizational decisions (though in diverse ways, as we have seen) about physical space, staffing, location, and alliances with religious authorities. Both of the clinics examined here maintain a strong sense of autonomy from any specific religious congregation, sect, or leader, and they provide an outlet for independent charitable action in a

culturally and ideologically pluralistic Muslim *ummah* (community). So, to adapt the words of U.S. Representative Maxine Waters, "If you want to see what American Muslims really represent," let us listen to the emerging stories of Muslim faith-based health organizations. While this is only one window on American Muslim identity, it represents a growing movement of influential and energetic Muslim Americans.

Endnotes

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22. I am indebted to my colleague, Kambiz Ghanea-Bassiri (personal communication, May 22, 2008) for pointing out the "performative" nature of these claims in response to an earlier version of this article.

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