

Holland & Knight

131 South Dearborn Street | Chicago, IL 60603 | T 312.263.3600 | F 312.578.6666
Holland & Knight LLP | www.hklaw.com

Joseph Hylak-Reinholtz
(312) 715-5885
jhreinoltz@hklaw.com

July 11, 2013

RECEIVED

JUL 12 2013

HEALTH FACILITIES &
SERVICES REVIEW BOARD

Via Electronic Mail to "mike.constantino@illinois.gov"

Mr. Mike Constantino
Supervisor, Project Review Section
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

Re: Preferred SurgiCenter, LLC (CON Project No. 13-007)

Dear Mr. Constantino:

This letter provides notice to the Illinois Health Facilities and Services Review Board ("State Board") of a modification to the certificate of need ("CON") permit application filed by Preferred SurgiCenter, LLC ("Applicant"). In this modification, the Applicant is making a number of changes to its proposal to establish an ambulatory surgical treatment center ("ASTC") in Orland Park, Illinois (i.e., CON Project 13-007). The Applicant's proposed modifications are responsive to questions and concerns raised by the State Board at its May 14, 2013 hearing, which resulted in the project receiving an Intent to Deny. While these changes are responsive to the questions and concerns raised by the State Board, they are more appropriately classified as modifications to the project and, therefore, are subject to the State Board's requirements at 77 Ill. Adm. Code § 1130.650. The Applicant's proposed changes that are described in this letter represent the second time the Applicant has modified this CON permit application.

Most of the modifications proposed in this letter are Type B modifications, subject to State Board rule 1130.650(b). However, the Applicant is also proposing one change that must be categorized as a Type A modification based on State Board rule 1130.650(a)(5). This modification, in particular, proposes to increase the categories of service from those stated in its original CON permit application. Type A modifications are subject to the public hearing requirements of the Illinois Health Facilities Planning Act; therefore, a check for \$2,000 is enclosed. Each of the changes proposed by the Applicant are discussed below in greater detail.

I. Background

On May 14, 2013, the State Board considered the Applicant's project for the first time. State Board members had some reservations about the project and issued an Intent to Deny. The Applicant submitted a letter to the State Board ten days later, which requested a rehearing on the project and reported the Applicant's intent to submit additional information to support the project. The Applicant indicated that the additional information would be responsive to questions and concerns raised by State Board members at the May 14 hearing.

The Applicant also requested a technical assistance meeting with the State Board staff to discuss the negative findings contained in the project's State Board Staff Report ("Staff Report"). The technical assistance meeting took place on June 6, 2013. During this meeting, the Applicant informed the State Board's staff of its intention to follow a different path. The Applicant, instead of simply providing additional information in response to the Intent to Deny, indicated that it would modify the project instead of simply providing supplemental information. State Board rule 1130.650(a) allows the Applicant to elect this course of action at any time prior to the State Board's final decision on the project. The issuance of an Intent to Deny is not a final act by the State Board. As a result, the Applicant is authorized to propose these modifications.

II. Discussion of Key Changes

A full, page-by-page, explanation of every modification is provided below in Section III of this letter. The following discussion, however, highlights the most significant changes that are being made to the application and explains how each change is responsive to a question or concern raised by the State Board at the May 14 hearing.

(a) General Changes to the CON Permit Application

(i) Shari'a Law

The Applicant is removing all references to Shari'a Law from the CON permit application. The intent of this change is to simplify and clarify the special health care needs of Arab-Americans and Muslim-Americans that the ASTC will provide. To meet these needs, the Applicant intends to employ bi-lingual staff that are sensitive to the needs of Arab and Muslim patients and who understand their social and cultural differences and how their individual set of values may impact the delivery of health care services to this particular group of persons.

(ii) Additional Categories of Service

Since the CON permit application was first submitted by the Applicant and the initial hearing on the project occurred, the proposed ASTC has generated a lot of interest from the community, the media, and local physicians. As excitement for the project grows, more and more physicians want to be involved with the project and have asked the Applicant for the opportunity to serve patients at the proposed ASTC. As a result, the modified application will seek State Board approval for two additional categories of service, bringing the total number of surgical services requested to six.

The following categories are proposed by the Applicant: (i) gastroenterology, (ii) general surgery, (iii) pain management, (iv) orthopedics, (v) obstetrics/gynecology, and (vi) podiatry. None of the physicians making referrals to the proposed ASTC will hold an ownership interest in the ASTC. For those surgical specialties that were not included in the original CON permit application, the Applicant is providing physician referral letters for these physicians.

(iii) Charity Care

The Applicant firmly believes that caring for the sick and the weak is a collective, societal responsibility. Because of this belief, the Applicant wants to re-emphasize its commitment to offer its patients a robust charity care program. The Applicant is planning to have a variety of initiatives in place to help individuals who live in the GSA obtain access to affordable health care services. The Applicant will provide a charity care program on a sliding scale basis, based on individual need. The charity care program will offer free or reduced-cost services and programs to GSA residents who are uninsured or underinsured. Moreover, the Applicant is committed to making all reasonable efforts to care for as many of the GSA's needy patients as it is financially able to accommodate. *The Applicant intends to provide charity care in the amount of at least two percent (2%) of its net patient revenue. This is about 100 times the state average for ASTCs.*

In addition, the Applicant also intends to implement a facility policy that requires physicians who are affiliated with the ASTC to provide charity care services as well.

(b) Changes Directly Responsive to Questions/Concerns of State Board

(i) Bank Letter

The Staff Report stated that the Applicant's CON permit application was not in compliance with seven of the State Board's surgery center review criterion. Two of these negative findings resulted from the State Board staff's determination that a bank letter was not sufficient to satisfy review criterion 1120.120 (Availability of Funds) and review criterion 1120.130 (Financial Viability). The Applicant is submitting a replacement letter from Citibank as part of these proposed modifications. *The letter, which was pre-approved by the State Board's staff, provides specific assurances to the State Board and should result in the rescission of these two negative findings.*

(ii) Non-Qualifying Physician Referrals

The State Board was concerned that the Applicant's CON permit application was based, in part, on physician referrals that were coming from unlicensed health care facilities (i.e., some physician referrals were not historically provided in hospitals or surgery centers, and instead, were provided in physician offices). The Applicant's partial reliance on non-qualifying referrals resulted in negative findings on State Board review criterion 1110.1540(c) (Projected Patient Volume) and on State Board review criterion 1110.1540(d) (Treatment Room Need Assessment). *The Applicant is modifying the CON permit application to reduce the number of treatment rooms from five (5) down to (4), which should result in the rescission of these two negative findings.*

The Staff Report stated as follows:

The applicant projects 5,020 procedures at 1.5 hours per procedure, which will justify the 5 procedure room being proposed. If the procedures materialize, the applicant will meet the State Board

July 11, 2013

Type A Modification Letter (Project 13-007)

standard. However, 1,704 of these referrals are coming from unlicensed health care facilities, which cannot be accepted as appropriate referrals under current State Board rules.

See Review Criterion 1110.1540(c) (Projected Patient Volume), Staff Report at pp. 18-20.

* * * *

The applicant is proposing five operating rooms. The number of projected procedures (5,020 referrals) will support the five operating rooms being requested. However 1,704 referrals were not accepted as legitimate referrals by the State Board Staff because the number of referrals came from unlicensed health care facilities. Removing those referrals, the applicant can justify 3,316 procedures. Using that number of referrals the applicant can justify 4 operating rooms (3,316 procedures x 1.5 hours) and not the five being requested.

See Review Criterion 1110.1540(d) (Treatment Room Need Assessment), Staff Report at pp. 20-21.

Based on the Staff Report's own conclusion, the Applicant is able to justify four (4) treatment rooms based on 3,316 qualifying procedures. ***Accordingly, the modification to reduce the number of treatment rooms to four should result in the rescission of these two negative findings.***

(iii) Reasonableness of Costs

The Staff Report issued a negative finding related to State Board review criterion 1120.140(c) (Reasonableness of Costs). Specifically, the Staff Report found that the project's site preparation costs totaled \$106,335, which was 5.6% of modernization costs and contingencies and exceeded the State Board standard by \$10,710. This slight overage resulted in a negative finding.

The Applicant's decision to reduce the number of proposed treatment rooms also resulted in a reduction of the project's overall cost. The Applicant made changes in the project budget that will ensure that this budget line does not exceed the applicable state standard. ***As a result, this negative finding should be eliminated.***

(iv) GSA-Specific Data Regarding Health Disparities and/or Access Issues

The Staff Report noted that existing ASTCs and hospitals within the Applicant's proposed geographic service area ("GSA") are not operating at the 80% target occupancy standard. The staff's report added that there was "no evidence that the proposed facility will improve access" to health care services. Accordingly, the Staff Report was negative on this review criterion.

The Applicant and the State Board's staff discussed this issue at the technical assistance meeting held on June 6, 2013. State Board staff indicated that the two studies included in the original CON permit application were not sufficient to show that the proposed project will improve access to care. Instead, staff said that GSA-specific studies and examples would be necessary to satisfy State Board review criterion 1110.1540(f) (Establishment of New Facilities). This particular review criterion provides that the State Board may approve a proposed ASTC if one of four conditions are met.

Section 1110.1540(f) provides as follows:

Any applicant proposing to establish an ambulatory surgical treatment center will be approved only if one of the following conditions exists: (1) There are no other ASTCs within the intended geographic service area of the proposed project under normal driving conditions; or (2) all of the other ASTCs and hospital equivalent outpatient surgery rooms within the intended geographic service area are utilized at or above the 80% occupancy target; or (3) the applicant can document that the facility is necessary to improve access to care, [and such] documentation shall consist of evidence that the facility will be providing services which are not currently available in the geographic service area, or that existing underutilized services in the geographic service area have restrictive admission policies; or (4) the proposed project is a co-operative venture sponsored by two or more persons at least one of which operates an existing hospital.

The Applicant is not submitting GSA-specific studies or information with these proposed modifications. The Applicant will, instead, be providing letters of support over the next two months that illustrate the health care needs of Arab-Americans and Muslim-Americans who live in the proposed GSA. ***The Applicant is confident that these letters will provide compelling evidence that the proposed surgery center is needed.***

Even though the State Board's staff has determined that the two studies addressing the health care needs of Arab-Americans and Muslim-Americans are not sufficient to meet this review criterion, the Applicant believes that these two studies provide examples that are equally applicable to Arab-Americans and Muslim-Americans who live in the proposed GSA.

The Applicant, therefore, emphasizes the importance of these two studies and encourages the State Board members to read these reports before the rehearing on this project.

The two reports are attached to this letter, which should provide State Board members quick access to these all-important studies. See Attachment A.

III. Summary of All Amendatory Changes

The following chart lists all of the modifications that are being made to the CON permit application for Project 13-007. The chart identifies: (1) the page number(s) from the original CON permit application that are being affected; (2) the page number(s) for the replacement pages; and (3) a brief narrative that discusses the proposed modification being made on a particular page. *The amended pages are attached to this letter as Attachment B.*

Crosswalk Table: Original CON Permit Application to Amended Application		
Page Number(s) in Original CON Permit Application	Page Number(s) in Amendment (Modification) to CON Application	Narrative Description of Change(s) From Original to Amended Versions
1	1	The CON permit application as amended inserts a new Page 1. In this amendment, the Applicant is removing information related to Primary Contact Clare Connor Ranalli. Ms. Ranalli left Holland & Knight LLP and was not retained as a project representative after moving to a new law firm earlier this year. Mr. Joseph Hylak-Reinholtz of Holland & Knight LLP is named as a Primary Contact for the project in place of Ms. Ranalli.
2	2	The CON permit application as amended inserts a new Page 2. Here, Mr. Joseph Hylak-Reinholtz is replaced as an Additional Contact by Mr. Jeffrey Mark. Mr. Mark's contact information is provided.
5	5	The CON permit application as amended inserts a new Page 5, which provides a revised project narrative. The new narrative reflects the terms of the modified project.
6	6	The CON permit application as amended inserts a new Page 6. The amended pages provide a revised chart for Project Costs and Sources of Funds to reflect terms of the modified project.
7	7	The CON permit application as amended inserts a new Page 7. The change made on the amended page is the insertion of a new project completion date.
10	10	The CON permit application as amended inserts a new Page 10. The updated page provides a new certification for the Applicant due to changes made in the CON permit application as amended.
15	15	The CON permit application as amended inserts a new Page 15. In this amendment, revisions reflect new categories of services added to reflect terms of the modified project.
17	17	The CON permit application as amended inserts a new Page 17. In this case, a revised chart is inserted to reflect new project costs resulting from the terms of the modified project.
58	58	A new Project Costs and Sources of Funds chart is provided to reflect the reduced cost of the project resulting from the reduction of treatment rooms from 5 to 4.

July 11, 2013

Type A Modification Letter (Project 13-007)

59	59	A new Cost Space Requirements chart is provided, to reflect the reduction of treatment rooms from 5 to 4.
66-73	66-73	The CON permit application as amended inserts new pages to provide a revised Purpose of the Project narrative. A new narrative is inserted to reflect the Applicant's intent to meet the needs of persons of Arabic and Muslim descent as opposed to establishing a surgery center based on Islamic law.
170-171	170-171	The CON permit application as amended inserts a new Alternatives section, amending pages 170 and 171. This provides a revised Alternatives to the Project narrative inserted, which removes all references to Islamic law and discusses, more generally, the goals of the project (i.e., to meet the cultural and language needs of Arabic and Muslim Americans).
172	172	The CON permit application as amended inserts a new Page 172. Provides a revised Size of the Project narrative to reflect terms of the modified project.
173	173	The CON permit application as amended inserts a new Page 173. Provides a revised Project Services Narrative to reflect terms of the modified project.
182	182	The CON permit application as amended inserts a new Page 182. The new page makes changes to Projected Patient Volume to reflect terms of the modified project.
183-184	183-184	Pages are deleted to reflect the removal of this physician, which occurred as a result of the Type B modification made in March 2013.
N/A	194A-W	The CON permit application as amended inserts new Pages 194A through 194W. These new pages reflect new and/or revised physician referral letters, which are made to reflect terms of the modified project, including the addition of surgical specialties not included in the original CON permit application.
195	195	The CON permit application as amended inserts a new Page 195. Reflects changes made due to reduction in the number of treatment rooms being sought by permit applicant, which are made to reflect terms of the modified project.
197	197	The CON permit application as amended inserts a new Page 197. Reflects changes made due to increased number of surgical specialties being sought by permit applicant, which are made to reflect terms of the modified project.
198	198-198C	The CON permit application as amended inserts a new Page 198. Revised page inserted, which includes additional entries in the chart to reflect charge commitments made to added categories of surgical services.

July 11, 2013

Type A Modification Letter (Project 13-007)

199	199	The CON permit application as amended inserts a new Page 199. A replacement charge commitment certification, dated as of the date the CON permit application amendments are filed with the State Board, is attached.
202	202A-202C	The CON permit application as amended inserts a new pages to accommodate a longer, revised bank letter from Citibank, which provides a letter with language pre-approved by the State Board's staff.
205	205	The CON permit application as amended inserts a new Page 205. Revised numbers/calculations based on terms in modified project is provided in this new page.
206	206	The CON permit application as amended inserts a new Page 206. Changes reflect a revised numbers/calculations based on terms in modified project.
207	207	The amended certification is updated with the same date as the Type A modification, submitted because the project costs changed.
213-216	213-216	A revised Safety Net statement is provided, changes the dates due to the delay in project approval.
217	217	A new Safety Net certification statement is provided because the original statement is being amended.
224-225	224-225	A revised charity care statement is attached to reflect new dates due to delays in project approval.
231-242	231	A new page 231 replaces pages 231-242. New page 231 references back to amended pages 182 through 194-W, which thoroughly discuss changes made to the underlying physician referral letters.

* * * *

If you have questions about this letter, or need additional information, please do not hesitate to contact me at (312) 715-5885. Thank you for your consideration.

Respectfully submitted,

HOLLAND & KNIGHT, LLP



Joseph Hylak-ReinholtzJHR/jhr

enclosures

ATTACHMENT A

Michigan Studies (Resubmitted Information)

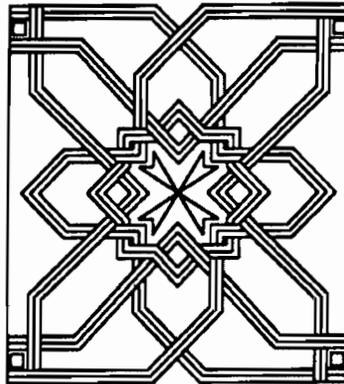
ACCESS

Arab Community Center for Economic and Social Services

Community Health Center

Public Health Education and Research Department

Guide to Arab Culture: Health Care Delivery to the Arab American Community



ACCESS Guide to Arab Culture: Health Care Delivery to the Arab American Community

Prepared by:

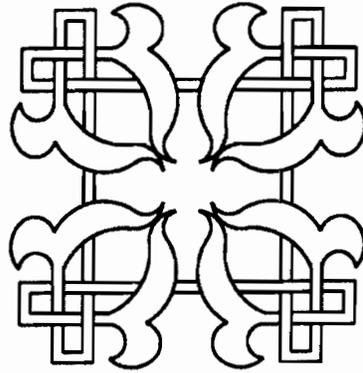
Adnan Hammad, Ph.D.,
Rashid Kysia, M.P.H.,
Raja Rabah, M.D.,
Rosina Hassoun Ph.D.,
Michael Connelly, B.A., B.S.

April, 1999

Copyright © 1999 ACCESS Community Health Center
Health Research Unit
9708 Dix Ave.
Dearborn, MI 48120
(313) 842-0700
FAX (313) 841-6340

ALL RIGHTS RESERVED.

No portion of this work may be reproduced in any form or by any electronic or mechanical means without permission in writing from ACCESS Community Health Center



Acknowledgements

The ACCESS Community Health Center is deeply indebted to each participant of this project, as well as, public and community health organizations and agencies. This Guide to Arab Culture will, hopefully, lead to more understanding to the Arab and Arab American cultural needs and how they impact health care delivery to the Arab American Community.

Our sincere gratitude goes to the Michigan Department of Community Health which, generously funded this project. We extend special thanks to our community agencies who gave their insight to this project .

ACCESS Community Health Center thanks the project team and colleagues who helped me to complete this project: Raja Rabah, M.D., Rashid Kysia, M.P.H., Michael Connelly, B.A., B.S., and Rosina Hassoun Ph.D..

We believe the present study will be of use for all decision-making, planners, community members, and all those interested in applied community health in general and the betterment of medically underserved Arab American health in particular.

Finally, this guide is an evolving project that will likely go through several iterations and editions in the future. We hope that it will prove useful and that feedback from its users will enable us to provide improvements.

Adnan Hammad, Ph.D.
Director, ACCESS Community Health Center
April , 22, 1999

Table of Contents

Foreword	iii
Preface on Medical Anthropology.....	iv
I. INTRODUCTION.....	1
Who is an Arab?.....	1
Immigration to the United States.....	2
II. ARAB AMERICANS IN THE STATE OF MICHIGAN.....	4
Socio-Economic Background of the Local Community.....	4
Environmental Health in Southwest Wayne County.....	5
III. HEALTH AND HEALING IN THE ARAB MIDDLE EAST.....	7
The History Of Arabic Medicine.....	7
Health Context of the Modern Middle East.....	9
<i>Traditional Sector</i>	9
<i>Development of the Modern Sector</i>	10
<i>Service Sector Structure</i>	10
<i>Service Availability and Accessibility</i>	10
<i>Public Health in the Arab World</i>	10
IV. UNDERSTANDING ISLAMIC SOCIO-RELIGIOUS BEHAVIOR.....	12
Basic Beliefs.....	12
Dietary Restrictions.....	14
Modesty and Sex Separation.....	15
Dependency on God.....	16
Fear of God’s Punishment.....	16
V. ARAB CULTURAL ISSUES IN HEALTH CARE.....	17
The Arab Family Structure.....	17
<i>Shame and Honor</i>	18
<i>Marriage and Divorce</i>	18
Children.....	19
Time and Social Interchange	21
Birth and Death.....	22
REFERENCES.....	25
APPENDICES.....	26
Appendix A: Other Salient Background Features Related to the Middle East.....	26
Appendix B: Arabic Phrases.....	28
Appendix C: Tables.....	29
<i>Table 1. Health Statistics from the Arab World</i>	29
<i>Table 2. Median Age at Marriage by Age Categories in Arab Countries</i>	30

Foreword

The need for a guide to Arabic culture designed specifically for health care providers grew from my own work and personal experience. As director of the ACCESS (Arab Community Center for Economic and Social Services) Community Health Center in Dearborn, Michigan, I have heard the Concerns of numerous Arab clients about their experiences with the Western health system. Funding agencies and other organizations have often requested information. Finally, it was also a recent personal experience that strengthened my determination to write this guide. The myths, stereotyping, and ignorance about Arab and Islamic culture stand in the way of providing sensitive and quality health care to Arab patients. The following cultural guide is designed to address these problems and to provide a detailed introduction to Arabic culture. The sections on health and healing in the Arab Middle East and on Islamic socio-religious behavior are designed to provide a practical and realistic view of Arab culture and Islam. The section on the health care sector in the Middle East is based on many years of experience in the management of health services in the Arab World and provides a unique perspective not found in other sources.

The following guide has been produced with the intention of addressing the lack of cross-cultural comprehension between the health providers and the Arab American health care consumer. It has been designed to help doctors, nurses, midwives, health administrators and planners to better comprehend the needs and preferences of the Arab American patient/client.

Though it is impossible to complete a cross-cultural bridge with one work such as this, we have put forth a beginning. We hope that you, as one involved in health care, will read and act on the content of this guide. The five sections will give you an overview of Arab culture and society and will provide you with an Arabic patient perspective you might not otherwise know. Included are specific anecdotes and descriptions that may parallel certain medical situations where an enhanced cultural understanding would be beneficial. The material contained in the appendix includes more in depth views of history, customs, and language, that you may read now or use to further your Arabic education in the future. We hope that you will read the main content of the guide as soon as you are able, for the sooner we share an increased understanding the sooner both you and those you serve in the health care field will benefit from it. Then keep this on a shelf or in your personal library, and use it for reference if you ever need it in the future. Regardless of your position in the health care field, we feel that this guide will be a foundation for you to establish a fruitful connection with your Arabic patients and partners in health. This is the beginning, your subsequent experiences will solidify and make the bridge whole.

It is our desire that health care providers apply this information with discretion, mindful of individual, regional, religious, and ethnic diversity within Arab culture. We hope that the end result will be more satisfactory medical experiences for both providers and patients.

Sincerely,

Adnan Hammad, Ph.D.
Director, ACCESS Community Health Center

Preface on Medical Anthropology

Anthropological Medicine:

"Sickness is, in essence, a condition of persons unwanted by themselves, and conceptions, theories, and experiences of sickness are elements of socially transmitted cultural systems...the anthropological perspective conceives of sickness in terms of the perceptions and experiences of patients. And the perception and experience of sickness by individuals is fundamentally shaped by their cultural setting. As individuals grow up in society, they are taught how to label their sickness experiences; they learn the cultural explanations of these conditions, the standard treatments, and the appropriate responses to others with the same conditions. It is the patient's experiences and life goals that define the distinction of normal and abnormal function"

(Robert Hahn 1995: 267)

We are living in one of the most volatile periods of human history- in an age when masses of humans and information race around the planet at incredible speeds. All things, including distant cultures and new diseases, are just a plane ride away. At this time in history there are more people living on this small planet than have ever lived before- all with a need for proper health care, sanitation, food, and a decent quality of life. The United States enjoys one of the highest standards of living but is also facing a challenge in providing quality health care for all. The 1980-1990's has been a period of very high immigration rates- cities like Miami, Chicago, and Los Angeles are now dominated by populations of immigrants that arrived since 1965. At the same time the numbers of foreign born physicians, social workers, and health care workers are also increasing. In addition to being a nation of immigrants, America has also become a worldwide backup health care provider for people who can afford to pay for American medical technology from countries around the globe. "Medical tourism", people visiting the US only for medical care, is an increasing phenomenon.

In the midst of these changes, the skyrocketing cost of health care has given birth to the concept of managed care. The rationing of health care and the numbers of patients per day has placed great pressures on physicians and health care providers. In the midst of this crisis in care, there is an apparent lessening of faith in biomedicine (the standard model taught in US medical schools). Concurrently, there has been a tremendous rise in interest in "alternative" health care. The number one complaint by patients is not about the type of medications or medical technology, it is that their doctors do not take the time to listen to them (Good and Good 1982).

Physicians and social workers are crying out for help in coping with patient expectations and with methods to deal with the rapid changes. Two decades ago, a health care worker would not have considered asking an anthropologist or a native healer to accompany them on rounds. Today, clinical anthropology, cultural and linguistic specialists, and integrated medicine (the integration of ethnomedicine, and/or "alternative" medicine with biomedicine) are not uncommon aspects of medicine in the United States. The need for specific cultural information on different ethnic groups and people of differing linguistic and religious backgrounds is increasingly important for health care providers and other care givers in American society. For this reason, this guide to Arab culture was written as another tool for care providers. With approximately 3 million Arabs in the United States and with American hospitals soliciting paying customers from the Middle East, the need for such information is greatest in states like Michigan, California, New York, and Illinois which have large populations of Arab Americans.

One of the dangers in writing a guide to a culture is that the guide reports on normative behaviors. In the case of this guide, the normative behaviors refer to recent unacculturated Arabs and cultural norms for the Arab World. Even in the Arab World there are 21 different countries, numerous sub-cultures, and religious and ethnic minorities. A great danger lies in the misuse of a little knowledge without critical thought. Diversity exists in every group of humans. In addition, the one greatest aspect of immigrant life is cultural change through acculturation and for some by assimilation. Therefore, any such guide must be applied with caution and common sense.

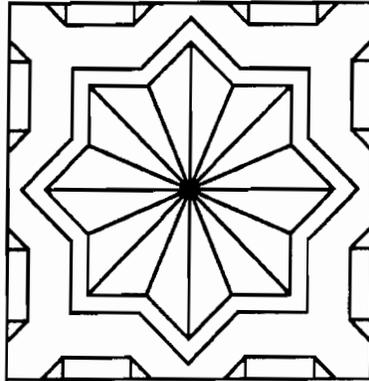
Each individual needs to be assessed along a scale of acculturation and change. We also must avoid jumping to assumptions. Just because a person wears traditional ethnic dress may not mean that they lack English language skills or if a woman wears traditional clothing that she does not work outside the home. And the converse may be true of someone wearing typical western clothing. We have to evaluate each person using a number of cultural clues and when in doubt learn to ask questions in a culturally sensitive fashion. We also have to be ready to reevaluate them as they undergo change.

On a recent trip to a physician's office, upon realizing I was an ethnic American the physician asked me if I did "anything weird" in referring to my cultural practices. Suffice it to say that I am looking for a new doctor. Learning to evaluate our own level of cultural competency is also part of the ongoing effort to provide better care. It is really difficult to be honest in performing a self evaluation of our cultural competence (see appendix) no one wants to admit that we may suffer from cultural insensitivity, cultural blindness, or in the worse case, harbor negative stereotypes and prejudice. It is also important to remember that no one, not even the most accomplished anthropologist, can be totally competent in and knowledgeable of all cultures. There is a learning curve with each culture and rather than emphasize our weaknesses, we can relish the feeling of accomplishment as we become more aware and comfortable with each new situation.

While working in the Arab community in Dearborn, Michigan, I remember seeing a particular young Arab girl. She was dressed in an extra large football T-shirt that almost covered her from head to foot, over a pair of blue jeans. She had on tennis shoes. She also wore a brightly colored scarf covering her hair and on top of it all a baseball cap worn backwards. On a number of occasions, I saw her on her in-line roller skates cruising the sidewalk. She had accommodated both her religious requirement for modest dress and the need for typical American teenage self-expression. I think of her often when I think of the Arab American experience.

Nothing in the typical American stereotyping of Arabs prepares Americans for dealing with the complexity of Arab culture. The gulf of misunderstanding between the West and East is large and runs in both directions. If ever there was a need for understanding between people, it is here. Hopefully, this small guide to Arabic culture will provide a first step on an adventure of discovery. Every culture has something of value to teach us, if we listen.

Rosina Hassoun, Ph.D.,
Medical Anthropologist



I. INTRODUCTION

Arabs in the state of Michigan are the third largest minority group and the fastest growing population in the state (Michigan Department of Health 1988). Despite this fact, knowledge of Arab culture has not increased accordingly among the general population. With respect to health care, many providers continue to find themselves in a position in which they are unable to understand the cultural patterns of their diverse patient populations nor comprehend the health-related behavioral motivations of these patients. Moreover, health providers tend to perceive client satisfaction from their own perspective, without the ability to view their clients' culturally specific perceptions of these services.

There has been a prevailing assumption in the health care field that the Arab immigrant patient should assimilate to the Western views of health and disease. From a health economy point of view, this assumption is flawed, since the burden of understanding must be carried by the provider more so than the consumer. Consumer satisfaction is measured by what the consumer him or herself feels about the service received, rather than what the provider perceives as appropriate service. Therefore, in our transforming American society, competence in understanding cultural diversity is an essential component in effective health care delivery. Understanding the Middle Eastern health environment, the cultural perceptions of health and illness, and the social factors that interplay in the patient's personal decisions are essential for the betterment of health service provision to this population.

Who is an Arab?

The term Arab is associated with a particular region of the world. Almost all of the people in the region extending from the Atlantic coast of Northern Africa to the Arabian Gulf (See map from Teebi, 1997) call themselves Arabs. The classification is based largely on common language (Arabic) and a shared sense of geographic, historical, and cultural identity. The term Arab is not a racial classification, but includes peoples with widely varied physical features. The total population of the Arab world is approximately 230 million in 22 nations (UNDP, 1993). As the map illustrates there are 10 Arab countries in Africa (Morocco, Mauritania, Algeria, Tunisia, Libya, Sudan, Somalia, Eritrea, Djibouti and Egypt) and 12 countries in Asia (Iraq, Jordan, Lebanon, Syria, Kuwait, Bahrain, Qatar, Oman, United Arab Emirates, Saudi Arabia, Yemen, and the people of Palestine. Palestinians are presently either living under Israeli rule, autonomy of partial Palestinian Authority, or dispersed throughout the

world). Despite the national boundaries drawn between the Arabs in the post-colonial period, the Arabs on the popular level view themselves as a unified entity.

Arabs are not homogeneous with respect to religious belief, but include Christians, Jews, and Muslims. The large majority of Arabs are Muslim (92%), however, in total the Arabs comprise only about 17% of the Islamic population worldwide (with other substantial populations in Indonesia/Malaysia, South Asia, Iran, Central Asia, Turkey, and Sub-Saharan Africa). The religion of Islam is closely associated with Arab identity because of the origin of Islam in the Arabian peninsula and the fact that the language of Arabic is the sacred language of the Holy Qur'an.

Within Arabic countries live other minority groups as well. Thus there may be found social and familial mixing with other groups such as Persians, Turks, Kurds, Berbers, and other minorities. Differences within Arabic culture also exist between those from urban versus rural areas. The makeup of specific Arab countries is quite variable, for example, while only 29% of the population of Yemen hails from city life, 84% of those in Lebanon call an urban region home. Fertility is high in the Arab world while so are many negative health indicators such as IMR (infant mortality rate), but no statistic is consistent throughout the Arab countries (see Appendix C) (Deeb, 1997). These varied backgrounds must be kept in mind when one tries to apply the cultural norms described in the following pages. No practice is universal, and behaviors and attitudes, while they may follow certain guidelines or common influences, are incredibly variable despite being born from the same culture.

Immigration to the United States

Arab immigration to the United States began as early as the 1890s and has been marked by distinct periods of population movement. The first wave of immigrants from the Arab Middle East was largely (90%) Christian immigrating from the then Ottoman Turkish administered district of Syria (which included Syria, Lebanon, Jordan and part of Palestine). These immigrants came to the United States seeking better economic opportunities. Among the minority of Muslim immigrants there were individuals escaping Turkish military recruitment after 1908 (Abraham, S.Y. 1981). Among all immigrants from the Arab Middle East, this first influx assimilated American norms and integrated into the society with the greatest ease and economic success. Of today's Arab Americans, 50% descend from immigrants that arrived in the United States between 1890 and 1940 (Abraham and Abraham 1983).

In the late 1960s, American immigration laws were relaxed and more significant numbers of immigrants from the Arab world began to arrive to the United States. Compared to the earlier immigrants, this population is proportionately more Muslim and the people more likely to have fled their homelands due to political and social upheaval. They were forced immigrants, many of whom were rural agriculturists who were entirely unprepared for life outside their previous environment. The waves of Arab immigration have corresponded closely to the tremendous political events of the Middle East in the post-colonial period. These immigrants include civilians displaced from Palestine in the formation of Israel (1948), and the 1967 Israeli occupation of the Palestinian West Bank and Gaza Strip, as well as civilians displaced by the Lebanese war of 1977-1992 (most significantly the full-scale Israeli invasion of 1982 and subsequent occupation of southern Lebanon), the Yemeni civil war (1990s), the Iraqi government persecution of the Shi'ite minority in the early 1980s, and the Gulf War coalition assault on Iraq in 1991. Each of these upheavals displaced civilians from ancestral lands. These displaced individuals are largely from

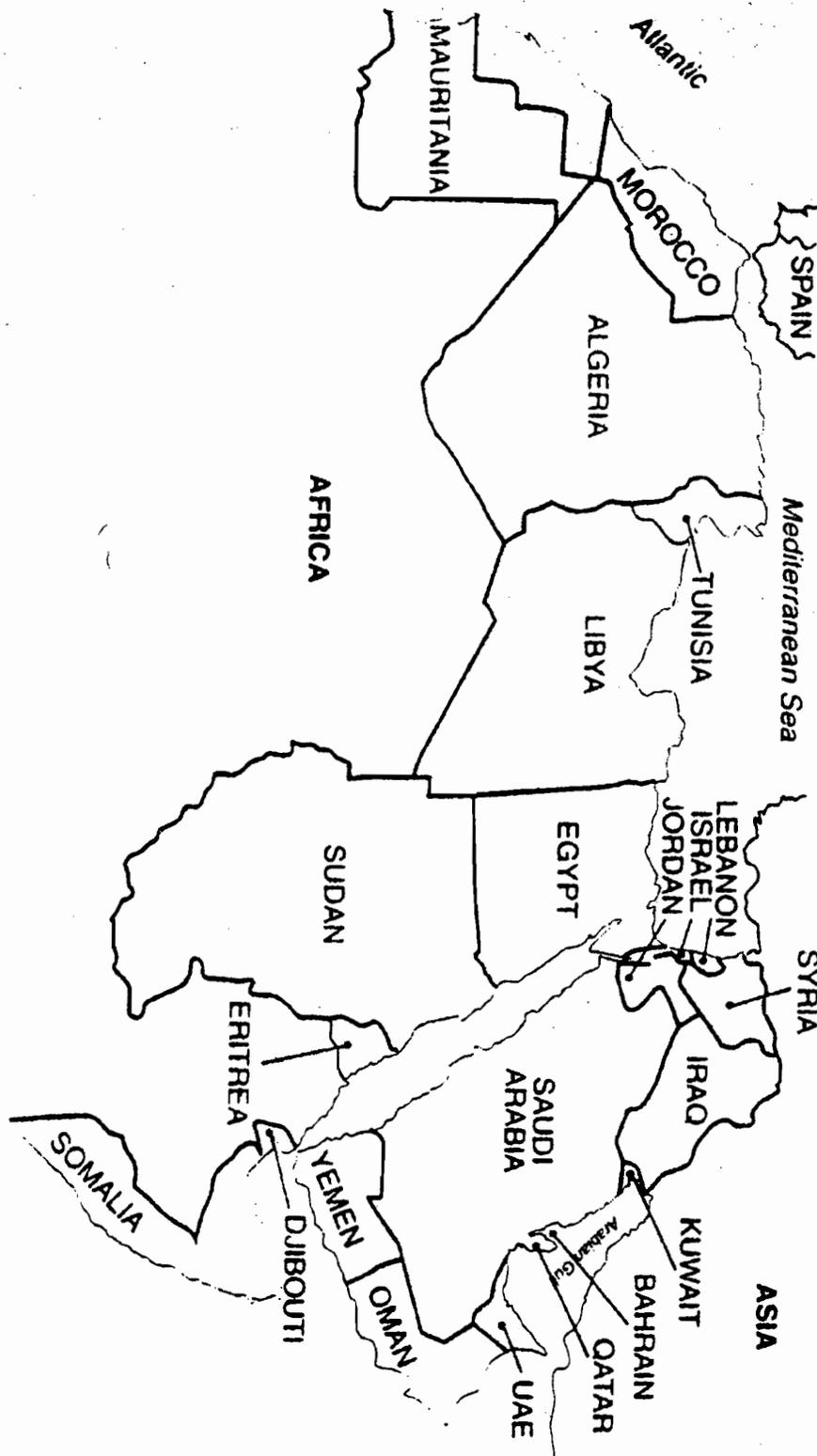
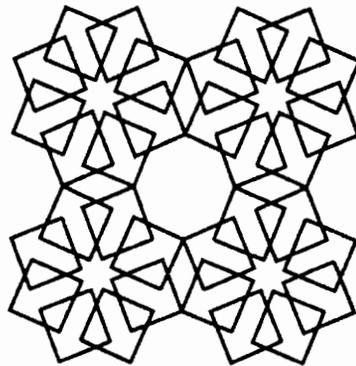


Figure 1-1. Map of the Arab world.

(The above map is from Teebi, A.S., 1997. "Introduction", in Teebi, A.S., Farag, T.I., eds. Genetic Disorders Among Arab Populations, 1997. New York: Oxford University Press).

agricultural backgrounds, representing some of the least technologically skilled and least educated segments of their respective nations of origin. Consequently, linguistic and social factors are significant barriers for health care access among many of the recent immigrants.



II. ARAB AMERICANS IN THE STATE OF MICHIGAN

Socio-Economic Background of the Local Community

The Arab population in the Metropolitan Detroit area is approximated at 250,000, 32% of whom reside in Southwest Wayne County (Abraham, S.Y. 1981). This community comprises one of the largest concentrations of Middle Eastern people living outside the Middle East, second only to Paris, France. The population varies according to political and religious affiliation and country of origin, but it is cohesively structured according to linguistic and cultural ties. The recent trend in immigration has weighted the Arab American population toward a greater proportion of immigrants born overseas (about 40%). In 1995, the Arab-origin population in Michigan had a median age of 27 years. This relatively young age is to be expected as immigrant populations tend to be younger than average. Sex distribution of the Arab population indicates that, in 1990, about 52% were males, while 48% were females.

Although the community is comprised of immigrants from varied geographic countries of origin, the cultural values are characterized by a great degree of uniformity. These cultural values play a prominent role in the health care seeking behavior among members of the community.

Employment activity, being the most important source of household income, directly affects living conditions. In 1990, the employment rate among the adult Arab population in Michigan was 69.6 %, while the remaining 30.4% were either unemployed or underemployed. Family structure among Arab Americans is predominately extended rather than nuclear. Kulwicki (1990) determined 49% of the population had five to eight persons living in the household. Statistics from the Office of the State Registrar indicate that about 20% of families in the Arab population are below the federal poverty line. This low income level for the Arab population has important implications in the unaffordability of health services for a large percentage of people. Many community members that are working, own or are employed in small shops or work several part time positions, and thus do not receive health insurance coverage through their employment. In 1994 the Wayne County Health Risk Behavior Report stated that 37% of the Arab population lacked health or medical insurance. This high rate of no medical insurance may adversely impact mortality measures and a broad range of health problems associated with obstetric care, mother and child health care, and other medical and surgical care. This high number of uninsured is expected to rise due to new federal legislation. Federal law will soon implement a policy in which any person who arrived to the United States

after August 1996 in a permanent residency status is not entitled to state Medicaid health coverage.

Literacy in English is low in the Southwest Wayne County community. Some of the residents are illiterate in both Arabic and English, while others are only literate in Arabic. Among these immigrants, educational attainment is low and employment skills are directed toward agriculture. Therefore, most of the work force in this community relies on unskilled jobs, largely in the automobile industry. As a result in the downsizing within this industry, the community has lost and continues to lose jobs. The unemployment caused by this economic contraction hits the Arab population particularly hard, since low educational levels and language skills make obtaining new jobs difficult.

Transportation is a significant barrier among low income Arab American families. A lack of transportation inhibits one's ability to access the health care system. Public transportation within the city of Dearborn is limited. Among the low income Arab American families that do have automobiles, the single family car is needed to transport the wage earner to work. Women and children are particularly affected by this barrier.

Lack of insurance coverage, and financial and linguistic barriers to regular health check-ups is predictive of a lack of preventive care and screening. Among the Arab population in Wayne County, members of low socioeconomic status are at particular risk for health problems since they tend to use medical care less regularly and neglect preventive health care, seeking attention for serious health problems only when they reach crisis proportions.

The most common leading causes of death among Arab females between the years 1989-1991 were: heart disease, cancer, cerebrovascular diseases, diabetes, accidents, and perinatal complications (Johnson, 1995). Among Arab males in the same period, the five leading causes of death were: heart disease; cancer; accidents; diabetes; and cerebrovascular diseases.

Health behavior among Arab community members in Wayne County additionally harbors a number of negative health risks. Smoking and sedentary lifestyle both are common in the Arab community in comparison to the general population of Michigan. Moreover, stress resulting from the transition to a different society and the social and economic difficulties associated with this transition might be an important contributor to poor health outcomes among the Arab population of Wayne County.

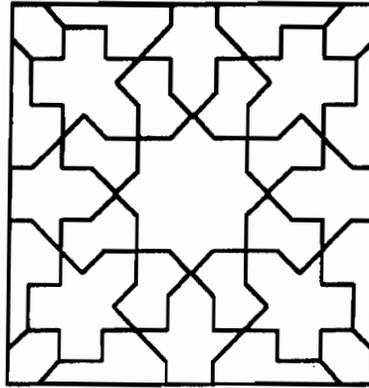
Environmental Health in Southwest Wayne County

The Healthy People 2000 report states "Environmental factors play a central role in the processes of human development, health and disease....efficient programs to improve environmental health must be based on primary prevention --reductions in the amounts of toxic agents used and released into the environment each year. Additional progress in improving environmental health will come from emphasizing the prevention of human exposure to agents already released".

The physical environment of Southwest Wayne County, particularly the South End community, is a clear ecological health risk. The South End of Dearborn is among the most highly industrialized areas in Wayne County, the worst county in the nation for industrially hazardous air emission (Savoie, 1995). The community is bounded on three sides by sprawling industrial complexes. It is crisscrossed with railroad and truck routes to neighboring industrial areas. The South End region has been the central location of Ford Motor Company car production since Henry Ford established the Rouge Plant. The Ford Rouge complex is a mile long industrial expanse that emits large amounts of particulate matter into the air. Surrounding industrial operations include Great Lakes Steel, Kasle Steel, Double Eagle Steel Coating, Detroit

Coke Corporation, Allied Tar Plant, Marathon Oil Refinery, and an array of other meat packing, waste disposal, and trucking industries running along the Rouge River. Particulate emissions are exacerbated by the high flow of slag trucks that transfer slag from steel plants to the Levy Slag Company, located behind the residential portion of the South End. Each day, these trucks drive through the neighborhood regularly, emitting hot slag vapors. Consequently, the air has a distinct unpleasant odor.

Research by Savoie (1995) using 1992 data from the Toxic Release Inventory found an exceedingly high level of toxic air emission exposure. The 13 auto-related sites within the South End are required to report emissions which indicate the generation of more than 138 million pounds of toxic waste in 1992. The total release of toxic material was 50 million pounds composed of a mixture of more than 30 chemicals released into the air, soil, and water. Among the chemicals released were carcinogens including benzene, chromium, and cadmium; chromosomal mutagens known to cause both birth defects and cancers; developmental toxins including cadmium, lead, and zinc; nervous system toxins including lead, mercury, dichloro methane, and xylene. Among the health effects of chronic exposure to these pollutants are kidney, liver, and cardiovascular complications, and respiratory illnesses like emphysema, chronic bronchitis, and asthma (Savoie 1995).



III. Health and Healing in the Arab Middle East

The History of Arabic Medicine By: Raja Rabah, M.D.

The sciences of health and healing among the Arabs is a tradition with roots in the earliest of recorded history. The distinct system of Islamic or Arab medicine (*unani tibb*) was formulated in its current form over one millennium ago (Hamarnah 1983:173-202). The impetus for the development of this healing system arose with the burst of Islamic civilization. In the 7th century AD, Islamic civilization emerged from the Arabian peninsula, expanding east and west and ultimately extending from Morocco and Spain (Andalusia) across the spice route to China. The Prophetic dictate to “seek knowledge as far as China” and the Islamic culture’s perception of itself as an expression of the primordial wisdom tradition stimulated widespread establishment of schools and centers of learning (Ibid 1983). The Islamic Caliphates of the 7th and 8th centuries encouraged the translation and study of scholastic works from a wide range of cultures. Islamic scholastic centers began to disseminate Islamic studies as well as absorb and integrate the scholastic inheritance of the ancient cultures, East and West. This emerging civilization synthesized wide ranging ancient Greek, Turkish, Indian, Persian, and indigenous Arab traditions within an Islamic framework, producing a comprehensive, analytic and scientific system of healing.

The Muslim scholars of medicine including Ibn Sina (Avicenna), Hunayn ibn Ishaq al-Ibadi, and al-Razi (Rhazes) revived and expounded upon the medical thought of Hippocrates, Dioscodres, Galen, and Plato, pioneering many of the elements of scientific medicine as it is known today (Hamarnah 1983:174-180). These scholars forwarded medical practice in both theory and application. For example, the physician Ibn an-Nafis predated Harvey in the discovery of pulmonary circulation (Ibid:180-82). Arab medical texts were among the foundations of the Western modern medical tradition; the canon of Ibn Sina formed half of the medical curriculum of European medical schools until the mid 17th century (Ibid:196-197).

In the 13th century, the Islamic sage Ibn Sina described medicine as “a branch of knowledge which deals with the states of health and disease in the human body, with the purpose of employing suitable means for preserving or restoring health” (Ibid). Microbial diseases were identified in a basic fashion (named *madah*) within Arabic medicine, and were described in terms of mode of infection and particular pathological effects on organs and tissue. Numerous internal and external etiologies were identified. In addition, Arab theorists noted that the mere presence of the germ did not constitute disease, but that the disease process was dependent on the state of balance of the exposed individual.

Islamic medicine followed the system of humoral pathology developed by Hippocrates. This healing system envisions the body in terms of humors-blood, phlegm, yellow bile, and black bile, corresponding to the elements of the natural world--fire, air, water, and earth. Each bodily humor possesses two natures. For example, blood is considered hot and moist, phlegm cold and moist, yellow bile hot and dry, and black bile cold and dry. The body brings together these four elements, and when this mixture is in equilibrium the human body is in a state of health. Within the humoral system, the humors were not defined as mechanical, but rather functional entities. For example, phlegm within the modern perspective has a specialized mechanical role in the body, whereas in the Arab humoral system, it is understood in a broader sense beyond the physical substance. It is a systematic functional entity, understood only in terms of its functional role in the balance within the whole organism in relation to the other three humors and three qualities.

Traditional cures were generally aimed at countering an excess or deficiency in one of the humors. For example, a particular problem might be described as an excess of cold and moisture that has invaded a particular humor or organ system. Pharmaceutical extractions might be prescribed and particular foods, spices, and teas might be taken to heat this system and to rebalance the humoral disunity. Beliefs about hot and cold effects on the bodily humors are maintained to varying degrees among Arabs as part of the transmitted cultural folk wisdom.

One of the most significant achievements of the golden age of Islamic medicine was the development of hospitals. The first hospital in the Islamic world was established as early as the 7th century in Damascus to help lepers, the blind, and disabled (Hamarnah 1983:178). This hospital utilized sophisticated methods of admission, discharge, record keeping, and administration. The early Muslim concept of the hospital became the prototype for the development of the modern hospital--an institution operated by private owners or by government and devoted to the promotion of health, the cure of diseases, and the teaching and expanding of medical knowledge. The hospitals attracted gifted students and were generously endowed by rich patrons (Ibid:179). Hospitals also served as schools of medicine to teach interns and residents. Through this system, an impressive method of testing and licensing doctors with rules and regulations for standards of practice was developed.

Islamic medical doctors utilized a variety of therapeutic approaches for the treatment of patients. Medical treatment relied primarily on exercise, baths, and diet and its modification. By the 13th century Ibnal-Bitar had recorded over 1300 drugs that were derived from plants, animals, or minerals (ACCESS Museum). Surgical techniques were known and utilized. Techniques were employed for fractures, treatment of trauma, and obstetrics. A number of Arab physicians compiled textbooks and case histories compendiums in the process of their professional duties.

The golden age of Islamic medicine extended from the 9-12th centuries. Islamic medicine did not disappear at the end of the Middle Ages with the unseating of the Arabic empire. It continued in the form of traditional healers following the Unani or Greco-Islamic system. In the colonial period, this Greco-Islamic system was undermined by emerging Western allopathic medicine and its administrative discouragement of the practice of the traditional system. The traditional health system of Arabs is still present to varying degrees throughout the Arab Middle East, though today, the number of adept practitioners (*hakim*) of the traditional Islamic medical system are few.

The traditional medical system is more pervasive in rural regions, while in the cities, Western technological medicine is now almost exclusively utilized. In other nations with significantly strong Islamic medical traditions, India and Pakistan state regulations have allowed

practitioners to be licensed after completion of special four year courses, where the curriculum includes the Canon of Avinciena.

While the Islamic system developed and expanded from the ancient Greek system, an additional system of folk belief exists in the Middle East. This system is also still prominent in the consciousness of many Arabs. Among the components of this belief are the acceptance of unseen forces that affect the individual. Within the traditional Arab world view, seen and unseen forces coexist within the material world. Unseen forces are thought to be in operation throughout the material realm, but veiled from the comprehension of most humans, excluding the spiritually adept who can perceive them. Some health disorders are attributed to unseen forces, most commonly jinn, or evil spirits. Mental disorders in particular are often attributed to the disruptive influence of these spirits.

The traditional view understands the human consciousness within this realm as a non-local entity, subject to influencing and being influenced by the thoughts and intentions of other individuals (human and jinn). There is a widespread belief that bad intentions toward a person can cause illness. The evil eye is said to affect a person when another individual is envious toward them, either knowingly or unknowingly. People are particularly aware of the evil eye around children. Turquoise pendants or verses from holy books are commonly worn. When a person complements a child, care is taken to mention God in the compliment so as to exclude jealousy that might make the child ill. These beliefs are ubiquitous in the Middle East and should be understood as an important part of the traditional world view to which disease causality is often attributed. It must be understood that the assumptions about health and illness held by Arabs is embedded in this time-held traditional system.

Health Context of the Modern Middle East

It is important for health practitioners to understand the Middle Eastern medical context in their Arab patients' countries of origin. It is this environment in which many immigrant Arabs' attitudes, beliefs, and practices toward health care were formed.

Throughout the Arab World today, the Western allopathic system of cosmopolitan/technological medicine is widely available, often through a socialized government system. Availability, however, tends to be much greater in the urban centers than in the rural countryside. In addition, in many regions there tends to be a private fee-for-service sector that provides care to more wealthy patients with greater perceived quality and decreased waiting times. Public health and health education tend to be limited in the Arab nations. The idea of preventive care is an unknown luxury. Moreover, health education is highly limited. The general level of public awareness about health issues tends to be low.

Traditional Sector

Alongside the Western medical services are a number of traditional practitioners for particular health needs. These practitioners are not officially established and certified by state mechanisms, but tend to exist in many areas as individual practitioners who have apprenticed and learned their skill from other expert lay practitioners. For example, in the Levant (Lebanon, Palestine, Syria) traditional bone-setters are still considered effective healers for broken bones and some people even view their services as superior to the Western method of bone-setting. Similarly, midwives in the Levant continue to be skilled attendants for birth. Birth in the hospital, however, is considered more prestigious.

Development of the Modern Sector

The health and medical services in the Arab world were entirely based on the above described traditional *Unani Tibb* system (see appendix) established prior to the colonial period. Superimposition of Western cultural norms and rise of technological medicine in the Middle East almost entirely replaced the role of locally-based traditional healers, except in more isolated regions. A biotechnological approach to health is predominant in health care thinking: searching for technological solutions. Health ministries, are purchasing MRIs while basic prevention measures (immunizations, primary care, public health, smoking cessation) are underdeveloped.

Service Sector Structure

In general, there are two distinct types of health providers in the Arab world: the government and the private providers. The government system is the largest of the sectors. These services are funded by general taxes and are established on the basis of a social insurance system. Government services are usually open for everybody, but the quality, efficiency, and effectiveness of this system is markedly inferior to private services.

Private services are for profit. They are owned by health alliances that are analogous to HMOs. These services are limited in number and access is limited to those who have the ability to pay up front for services or through private insurance. Private services are perceived to be of better quality and impart higher social status. The private services for profit provide private doctors, tertiary care, and private labs. There are also numerous private obstetrics and gynecological hospitals.

Health ministries in the Middle East, in general, have a strong urban bias in their priority distribution of medical and health services geographically. Practically all comprehensive secondary and tertiary care is provided in the city. In contrast to the United States, the majority (over 60%) of the Middle Eastern population is based in rural agricultural regions. In these rural areas, the private for-profit health sector is virtually non-existent. The government health system normally provides limited secondary health services in these regions, though long distances must often be traveled from outlying areas to obtain these health services.

The urban bias for medical services is compounded by the desirability of urban practice in the perception of many doctors. Doctors tend to think that city practice is more prestigious and a greater experience than is rural practice. Many doctors trained in biotechnological techniques find the rural centers under-equipped without 'high tech' implements and even deficient of more basic equipment. Residents from rural areas generally visit the rural primary care centers for most conditions, and only travel to the city for care when they are very sick.

Service Availability and Accessibility

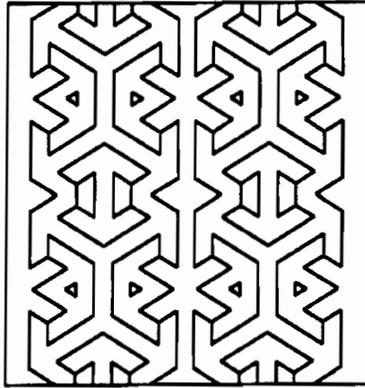
Due to the government sector provision of health care services, many poorer individuals in the Arab world do not obtain medical insurance coverage for private services. In general, these government services are accessible and are available to all citizens.

Public Health in the Arab World

Due to the bureaucratic nature of many Arab health ministries and the lack of a uniform system of record keeping in many areas, public health is notably under-developed in many Arab countries. Epidemiological data is difficult to obtain due to the lack of consistent medical charting and absence of health information collection at the state level. Consequently, epidemiology and disease morbidity/mortality tracking is conducted in a decentralized manner by associations of physicians, NGOs (non-governmental organizations), limited regional health

studies, international health bodies like the World Health Organizations, and to a limited extent, government health ministries.

Without high priority for public health, health educational materials are limited and health promotion is only in nascent form in many Arab nations. There is little widespread public discourse about health (e.g. cancer prevention or early detection screening, cholesterol, high-fat diet) putting the entire health sector at a disadvantage.



IV. Understanding Islamic Socio-Religious Behavior

Basic Beliefs

Islam is the second largest religion worldwide and is the fastest growing of the world's religions. The word Islam means submission to *Allah* (God) and is a derivation of the Arabic root *salaam*, meaning peace. A Muslim is literally "one who submits to the will of God". The system of Islam was established in the 7th century A.D., though Muslims consider Islam to be the primordial religion of devotion to God that began with the first human, Adam.

The religion of Islam is considered by Muslims as the continuation of a line of monotheist prophets, said traditionally to be 124,000 that came to different people in different times. Among these prophets are the prophets of the Abrahamic line shared in common with the Jews and Christians -- Adam, Noah (Nooh), Abraham (Ibrahim), Enoch (Idries), Moses (Musa), Soloman (Suleyman), David (Daud), and Jesus (Isa). The Prophet Muhammad, who lived in the 7th century AD, is considered the final prophet and the messenger of the final universal law for all humanity in all subsequent times. Muslims view Islam as the final synthesis of the previous revelations, including Judaism and Christianity, and accept belief in the afterlife and Final Judgment. Islam emphasizes respect for the adherents of these preceding religious forms, that of Judaism and Christianity, referring to them as *Ahl al-Kitab* (People of the Book), and considers them in a privileged status within the Islamic system. This status protected their rights as a religious minority and encouraged the People of the Book to rule themselves by their own scriptural laws.

The sacred scripture revealed to the Prophet Muhammad, the Qur'an, is considered by Muslims as pure Divine revelation and as such is the ultimate source for the judgment of human behavior. Because of the perception of the Qur'an as divinely revealed, the norms set down within the codified Islamic law are considered absolute and are not believed to be subject to temporal change. Thus, the injunctions of the Qur'an are the ultimate source of behavioral norms and social allegiance, above all man-made laws and norms.

The division of Muslims into Sunni and Shi'ite occurred on the basis of the differences between the early Muslim community after the death of the Prophet, Mohammad. The schism resulted over conflict of who was to be the Prophet's rightful successor and what was the proper method of adherence to the Qur'an and the Prophet's sayings. Despite these differences, all Muslims adhere to an essentially uniform practice with respect to the fundamentals of Divine Law and religious obligation.

Islam is a complete way of life--a social, economic, spiritual and political system. As such, it is different from religion as understood in the West. In the current Western world view,

religion and daily life tend to be viewed dichotomously, whereas the Semitic traditions of Judaism and Islam both viewed all aspects of life within the context of religion. Islamic Divine Law (*shari'a*) is believed immutable and Islamic norms are considered the ideal towards which Muslims strive to conform in all societies at all times. Islamic injunctions based on the Qur'an and way of the Prophet Muhammad (the *Sunna*) are outlined for an array of practices of daily life. These practices range from spiritual actions like prayer and meditation, to washing, eating, dress, economic activity, rules for war and peace, relationships and roles in society, family interactions, marriage, birth, and death.

The five fundamental pillars of Islam are: 1) *shahadatan*, testimony of the unity of God and the prophethood of Muhammad, 2) prayer five times daily (*salah*), 3) almsgiving and social responsibility to the poor (*zakah*), 4) fasting during the month of *Ramadan* (*sawm*), and 5) performance of the pilgrimage to Mecca, the *Hajj*.

Among the basic pillars of the religion that a health professional would be most likely to encounter is the Islamic prayer and fasting. Prayer is required in Islam five times a day (before sunrise, noon, midday, sundown, and nighttime), and must be preceded by a ritual ablution. This ablution is called *wudu'* and Islam stipulates that the performance of this washing include intention to purify one's bad acts and the washing of the mouth, nose, face, ears, back of the neck, hands, arms up to the elbows, and feet to the ankles. Prayer includes the recitation of certain Qur'anic verses and series of prostrations to God in the direction of Mecca (East). Sick patients who are unable to pray with full prostrations are allowed to pray sitting up in a chair or bed, and if that is not possible, then allowed to pray in the position from which they cannot move. Obligations are removed when health is threatened. Keeping this in mind health care professionals should be aware and respectful of these needs for prayer should a Muslim patient want to exercise his or her religious obligations. Clinical staff should not be taken aback if a patient asks them, "which way is east?", and staff may even volunteer this information if they know the patient is religious.

An additional pillar encountered by health professionals is the fast. Muslims observe a month long period of fasting from any sexual activity, food, or drink from dawn until dusk daily, as stipulated by the Qu'ran during the lunar month of Ramadan. Fasting is considered a method of both physical and spiritual purification and as a means to annually re-acquaint the observer with the physical sensation of hunger to foster empathy toward the poor. Because Muslims follow a lunar calendar year, the time of year that this month occurs by the solar calendar each year varies. Muslims are exempt from the fast if they are traveling or if their health is jeopardized. Women are not required to fast during menstruation or forty days postpartum. Fasting is dictated by medical considerations while women are pregnant or nursing.

Despite their illness, the Muslim patient may attempt to fast during this month. This fasting would involve the refusal of any food, drink or other substance (including pharmaceuticals) from before sunrise to after sunset. This would involve the refusal of I.V.s, tablets and enemas. If this appears to be a life threatening situation, health care practitioners may talk with an elder in the patient's family or an Imam from the community Mosque who may persuade the patient that in his or her current state fasting is not appropriate. For the Muslim patient observing the fast, a light meal (*suhour*) before dawn should be provided. At the time of sunset, a larger meal is taken (*iftar*) and this meal is often eaten with a group of other Muslims. Considerations should be taken for the family of the patient who might require different visiting hours, and the probability of mental fatigue toward the end of the fast. These circumstances should also be understood for Muslim health care personnel.

At the end of the fasting month of Ramadan, Muslims celebrate one of two major religious holidays (*Eid al-fitr*) during which people of the community gather and have feasts. At the end of the hajj season, a second holiday, *'eid al-adha* is celebrated.

The concept of human freedom is understood differently in Islam from that of Western culture. Whereas in the West freedom is viewed in terms of freedom of action and personal independence, the Muslim understands freedom only in the context of social and spiritual considerations. The individual as such does not have absolute freedom or rights except through fulfillment of social and religious obligation. Such considerations apply to all spheres of life, including health behavior. This translates into the Muslim's conception of "self" being less individually defined, but instead defined by the family and participation in the Islamic community.

Misunderstanding of the totality of religious practice in Islam leads non-Muslims to form misguided topics for dialogue with Muslims and blocks their understanding of the Islamic perspective. This may translate into a number of cultural clashes related to medical care. The Islamic world view tends to emphasize the will of God as the mover of all actions and the originator of all fate and events. The humility and the dependency of humans on God are often stressed, so that it is common for Muslims to attribute some personal achievement to Allah, but fault the errors to the human being. Moreover, the Islamic norm for politeness includes not making definite assertions about the future. Instead of saying *this disease is curable or we will come here next week-* the Muslim will almost invariably add *In sha Allah--God-willing*. A conscientious health provider might also incorporate such a statement as "God-willing" when making assertions about the future, as the Muslim tends to perceive bold assertions about the future as arrogant disrespect for God's will and an open invitation for disaster.

The rewards and punishments from God are not limited to the afterlife, but instead can occur in the present life as well. Muslims tend to view calamity as a test that tempers the individuals spiritual development. Stories of the affliction of Job, the trials of Joseph, and Jonah in the whale are all examples of this perspective for Muslims. Although the Bible and Torah also contain similar accounts, Muslims tend to place more emphasis on these lessons than might Jews or Christians. Therefore, Muslims are sometimes perceived by health providers as fatalistic in their acceptance of bad health outcomes. This is largely the result of miscommunication between differing world views. Additionally, Muslims may sometimes be resistant to the idea that their disease is the product of a carcinogen or risk behavior rather than the result of Divine Will.

One religious tradition extols the benefit of visiting the sick. Therefore, it is common to see community members that are not related to the patient come to visit a sick Muslim. Health care professionals should understand that the extensive social support received by the Arab patient is an important part of recovery, and *not* an impediment to medical therapy.

Dietary Restrictions

Islamic law, similar to Judaic religious law, stipulates a well-defined dietary code. Consumption of pork is entirely forbidden by Islam. This has presented ethical issues in modern times, as some medical products are produced through pigs and other animals. For example, genetic research has developed the ability to produce medically usable forms of insulin in pigs. Lard, gelatin (unless specified as beef gelatin), and some forms of non-soy lecithin, are pork products that are generally widespread in processed foods. Because of the prominence of these products in prepared foods, the Arab Muslim patient is often wary of hospital meals.

Based on the Qur'anic injunction against consumption of meat killed other than in the name of God, most Muslims only consume meat that is specially slaughtered according to particular standards (*halal* meat). These standards include humane treatment of the animal while slaughtering, making of a prayer and invocation of the name of God before slaughter, and draining of the animal's blood. Kosher meat is roughly equivalent to *halal* meat for Muslims. If the hospital has taken steps to prepare *halal* or Kosher meals, the Muslim patient should be reassured of this so they may eat comfortably.

For Muslims, alcohol may not be consumed in any form--as beverage, in cooking, or in non-emergency medication. Consumption of alcohol among Muslims is considered shameful and therefore abuse of alcohol and intoxicants is less common among Muslims than the general population.

Modesty and Sex Separation

Although there is considerable variation in degrees of separation in the sexes in the different Arab countries, generally male/female interaction in Islamic societies is limited to the family unit and is explicitly defined by Islamic law. Sex separation is generally observed in public interactions, including separation within adolescent and adult hospital wards. It is generally inappropriate for non-family members of the opposite sex to approach for conversation or other casual encounters. Hand shakes between non-related men and women are considered improper according to Islamic norms. However, there are really four different philosophies of Islam proclaiming varying degrees of contact to be inappropriate. There are some Muslims who would expect a handshake regardless of the gender of the health practitioner. Because of this the practitioner may always extend his or her hand with the awareness that a refusal from the other party to do the same should not be considered insulting.

Eye contact is frequently avoided, regardless of Islamic philosophy. This is most often true for cross-gender interactions, the female patient might not look directly at the male practitioner when speaking or the male patient might not look directly at the female practitioner when speaking. This will naturally vary with the duration the patient has lived in a society with Western norms.

A married person that looks upon a member of the opposite sex with improper intention is considered to have committed the spiritual equivalent of adultery. Therefore, much of the Western fashion esthetic and emphasis on physical appearance in order to be attractive to the opposite sex is considered spiritually and socially damaging by Muslims. Health education messages that emphasize looking trim or utilize models that are scantily clad are ineffective for reaching a Muslim population.

Outside of the extended family unit, men and women do not tend to interact socially. Related to this is a conservative norm for modesty in Islam. Stipulations exist within Islamic law that dictate a specific amount of covering that is permissible in front of non-family members. Short or exposing clothing for both men and women, but particularly for women, is considered contrary to proper modesty behavior. It is important for health professionals to realize this requirement when examining Muslims of the opposite sex. In general, same-sex providers should be made available if possible and examinations in front of other individuals (for example, opposite sex medical interns or assistants) should be avoided. In Islamic law, these norms are suspended for life-threatening emergencies only. Strong modesty norms make issues that are related to reproductive health embarrassing. Keeping this in mind when interpretive services are needed, same sex interpreters are desirable, particularly for female patients. If this is not possible an interpreter who is of opposite gender of the patient will suffice.

Dependency on God

Islam could affect the outlook on life and the everyday behavior of the Arab Muslim. Although the official teaching of Islam is largely ignored, the people in Arab society have developed a philosophy of life that includes the following religious traditional values:

- 1) a feeling of dependency on God
- 2) the fear of God's punishment on earth as well as in the hereafter
- 3) a deep-seated-respect for tradition and for the past
- 4) politeness to all and generosity

'Insha'a Allah', or the phrase 'if God wills it', looms large in the thinking of the average Arab Muslim. Implicit in this saying is the fatalism which is characteristic of most of those who use it. One hears this phrase repeated constantly, frequently in reply to a question and after looking to the future.

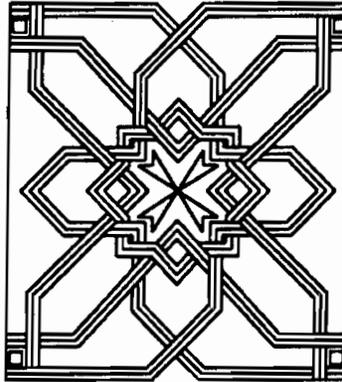
If something is lost or goes wrong, for example death etc., the Arab Moslem would not stop to examine the causes for the loss, but will merely sigh philosophically 'this is the will of God'. This phrase will similarly be reiterated by friends and relatives of the bereaved. Lutfiyya (1970) states that the same philosophy was evident in a discussion on Poverty and Birth Control that took place in one of the coffee shops in a village. The consensus of those present was that all children were born simply because God willed it. No child is born without his 'ruzq' (livelihood) being sent down from heaven with him. Hence the child is never a burden to his family'. It is God who decides how much property and wealth anyone should have. How unwise and foolish then of anyone to try and limit his offspring, hoping that this might increase his wealth. Indeed, to practice birth control is to oppose the will of God.

The dependency on God is so strong that it tends to manifest itself in almost every phase of the Arab Moslem's behavior. It is perhaps this 'dependency on God' which evokes the greatest desire to challenge when, for example, an Arab comes to the U.S., the student has been exposed to a society which seeks reason or motive for an accident or other events, rather than acknowledging interference from a divine power (Hammad, 1989).

The fear of God's punishment

Arab Muslims, as noted above, feel that God keeps a very close 'watch over them. God is interested in his everyday behavior, he will be punished for his 'bad acts', and rewarded for his 'good'. Consequently, if he commits a sin or undertakes a move which might be construed as sinful, he will ask himself "Would God be pleased or displeased with my behavior?" If he subsequently proceeds to commit the sin, he lives in fear of God's punishment and hopes that he might appease God by repentance and doing good deeds in the future. Laboring under this sense of guilt, the Arab Muslim is apt to interpret any ill-fortune that befalls him as God's retribution for the wrong he has committed. For example, a traditional Arab Muslim may report that two days after he had committed adultery, one of his sons drowned.

In summary, the fear of God's punishment tends to direct the Arab Muslim to take a course of action in his daily behavior that is in keeping with Islamic ethics. Alternatively, the idea that God can be appeased and that his forgiveness can be obtained by repentance and the offer of sacrifices, leads many Arab Moslems to deviate from Islamic teaching and to commit criminal acts (Ibid).



V. Arab Cultural Issues in Health Care

The Arab Family Structure

Sociologists for many years have stressed the family unit as the basic social institution of society. In the Arab world, the family structure is much more rigid and highly emphasized in comparison to the West.

Four types of family units are found in the Arab Middle East. The first and most simple structure is the nuclear unit, which consists of the father, mother, and offspring. This type of family unit is the least significant in the culture of the Arab world. Such limited units are most prominent among urban, upper class, Westernized individuals. In the rural regions where the traditional Arab norms are most intact, this form of limited unit is virtually non-existent.

The second familial unit is the *'aila* (the extended family) or the joint family. It consists of father, mother, unwed children, as well as wedded sons and their wives and children, unwed paternal aunts, and, sometimes, unwed paternal uncles. In short, this unit is composed of blood relatives plus women who were brought into the kinship through marriage. Large as it may be, this unit is an economic as well as a social unit and is governed by the grandfather or eldest male.

The third type of blood kinship unit is the *hammula*, or clan. It consists of all individuals who claim descent from the same paternal ancestor. The Arab village community is normally composed of three or four such *hammula* units, which may be called the *qabila*, and each of these units of *hammulas* are composed of several joint families.

The Arab family is the center of all loyalty, obligation, and status of its members. The social, psychological, and economic security of the Arab individual stems from membership in the extended family and this membership is the primary motivating factor for the decision making of the individual. The individual identity in Arab society tends to be much less important than the identity defined by the extended family affiliation. Family relationships are the ultimate standard to which the individual seeks social approval. The individual's loyalty and duty to his or her family are greater than any other social obligation.

From birth until death, the Arab individual is always identified with other members of the Joint family in name and social status. Once a child is born to a young couple, the people stop referring to the parents by their first names and begin calling them after the name of their child--for example, *Abu Anwar* (father of Anwar) and *Umm Anwar* (mother of Anwar). A child also adds the name of his father to his own name and often precedes it with the word *ibn*, which

means "son of". Women are related in the same fashion through the patrilineal line, and they maintain such identification even after marriage; though women do not add their husband's name to their own after marriage.

All members of a *hammula* identify and relate themselves to one another in a very systematic way. For example, a young man refers to every one of his fellow young men of the *hammula* as *ibn 'anim*, or "paternal first cousin". The same for every one of the young women referring to each other as *bint 'amm*, or "paternal female cousin". Such a system of identification shows that the Arab is necessarily a family-oriented individual, and that he is always considered an integral part of a much larger family unit than the biological one. His loyalty is always greatest to those closest in kin, but it transcends even these individuals to include the *hammula* and village to which he belongs, rather than the place in which he may be living.

Shame and Honor

The feeling of kinship is so strong that the easiest way to insult an Arab is to curse one of his relatives. In an Arab's eyes, the *hammula* rather than the individual is held liable in the event of dispute or conflict. Conflicts or feuds are not normally settled by individuals, but rather settlements are mediated through an agreement of the *hammula*. In an event of a monetary settlement, the entire *hammula* is expected to contribute to such a fund.

Shame and honor are highly emphasized within this context, and personal bad action not only dishonors the individual, but also the entire family unit. This norm has a great deal of bearing on health behavior. Social norms are conservative--disapproving of out-of-wedlock relations, homosexual relations, and drug or alcohol use.

Mental illness is a condition that is highly shunned in the Middle East. While Islamic norms dictate kindness and care be given to the mentally ill, Arab social norms tend to approach mental illness with fear and social avoidance. It might be said of the ill person that he is touched by demons (*jinn*) or that God is punishing him. While it is acceptable to disclose mental stress, a breakdown is considered totally shameful and blameworthy for the individual, for his or her family, and in some instances, for his or her village.

Both chronic diseases, and mental illness are viewed as a matter of shame with this context. Illnesses are generally hidden from disclosure for fear that people will view the condition as a sign of hereditary defect or as an indication that the family has earned the wrath of Divine Will, which might affect the social standing and marriageability of all associated family members. An example was an Arabic woman who refused further diagnostic work-up after having mammogram suggestive of malignancy. Her refusal was based in her belief that if it is known that she is going to the clinic for evaluation of breast cancer her daughter would be undesirable to other families in the community as a marital partner. Only after strong reassurance that all proceedings and testing would be confidential did she comply to seek further follow-up. This has important bearing on the level of disclosure an outside surveyor, including a physician, will be able to uncover in a health interview. As described, the sick individual would often prefer to hide than to seek care and face open disclosure of the 'defect'.

Marriage and Divorce

Marriage is viewed as the basic constructing unit of a strong society and is highly valued. The emphasis of marriage and natality is an ever-present social pressure among Arabs. From the youngest age, people often wish the child '*farahatik*', happiness on your wedding day. The age of marriage for women is low in comparison to United States averages and many Arab women have married during their teenage years.

Marriage is often arranged to secure wealth within a family. Thus, while marriage between two first cousins may be considered incestuous in the American context, it will be socially acceptable in Arabic contexts. The most common form of familial marriage is between paternal first cousins. In the Arabic world the rates of intermarriage range from 25% in Beirut to 90% in the Bedouins of Kuwait and Saudi Arabia. The average rate for most Arabic countries is about 40%. This practice may predispose some groups to genetic disorders including certain hemoglobinopathies (Teebi, 1997).

While Polygyny is allowed in the words of Qu'ran, it is not frequently practiced. From estimates of polygynous rates in the 1970's and earlier, in most Arab countries, less than 5% of Muslim men had more than one wife (Deeb and Sayegh, 1997).

Two fundamental generalizations may be made about divorce. First, obtaining a divorce is often more of a man's privilege. Secondly, the problem of divorce has never been as great in the Arab community as it is in many other parts of the world. Divorce is very rare among Arabs, especially in rural areas since marriage is viewed as a relationship between two hammulas rather than two individuals.

Women face some difficulties in their attempts to obtain a divorce, since the husbands agreement to the divorce is necessary. However, a woman can bring a suit against her husband in front of a *mahkamma shar'iyya* (religious court) and pronounce acceptable reasons for divorce. A number of conditions under Islamic law validate the woman's divorce. The man is required to pay for food, clothing, and shelter for his wife and children, and failure to do so is grounds for dissolution of the marriage contract. *Shi'i*, legal scholars, even recognize sexual dissatisfaction as fair grounds for acceptance of a woman's divorce petition, thus alleviating the possibility that the woman will seek satisfaction outside of the marriage and create a serious social ill.

In spite of the ease with which the man may obtain a divorce, very few husbands resort to divorce. This is so for a number of reasons. The religion of Islam, although permitting divorce, discourages it and teaches that reconciliation is better. Islam recommends to its followers that if they fear a breach between a couple, they "appoint a judge from his people and a judge from her people; and if the two desire an agreement, Allah will effect harmony between them" (Qur'an 4:35). The Prophet was reported to have said "with Allah, the most detestable of all things permitted is divorce".

Non-religious factors also discourage divorce. Important among these is the economic loss involved in a divorce case, i.e. *al-muajjal*. In addition, familial intervention usually prevents most divorce cases from happening. For emotional reasons, most men prefer to remain married to the same woman rather than divorce her and allow another man to marry her. Divorce is also considered a shameful act among the Arabs, and individuals worry that once they divorce, it will be difficult to remarry. This is reflected in an attitude that "if she was worthwhile, her husband would not have divorced her". A reciprocal, though not as prominent, attitude looks down on the divorced man.

Children

Natality is highly respected as an Arab cultural norm. The pregnant mother is given a lot of attention from members of the family and community. A woman is often seen to be truly mature by other women only after bearing a child. Infertility within the context of marriage is viewed as a mark of shame rather than a medical condition. It can ultimately be the cause of marital separation due to the level of pressure applied by the couple's extended families. Family pressure, similarly, tends to create strong incentive for large numbers of children.

Having children as heirs is a strong motivation for marriage. The birth and care of children, especially males (who act as future means of security for the parents) play a very important role in Arab culture. As a general principle, all children born in wedlock are regarded as legitimate and viewed as gifts from God. A marriage that produces many children is considered a blessed match.

The Arab family invests a great deal of love and expectation in their children. A well-developed system of etiquette is present within the Arab family for relationships between parent and child. In general, children are highly obedient to their parents and view this obedience as a lifelong commitment that supersedes all other social commitments, including marital allegiance. Children are encouraged to live in the parents' home until marriage, and little pressure exists for the child to seek his/her own social independence. Similarly, it is shameful by Arab cultural standards to place a parent in a nursing home instead of providing the care for the parent within one's own home. The responsibility of raising children in the Arab family is extended to all adult family members, and creates a network of support that eases the burden of high natality.

Discipline of the child tends to be punishment-oriented rather than reward-oriented. In Arab norms, light physical discipline and strong verbal reprimands of the child or even screaming at the child is considered proper parenting and is viewed as correcting the child's etiquette (*adib al-walad*) rather than being seen as violence. This physical discipline most often is spanking, but may include slapping the face or hitting the body of the child. It must be emphasized that hurting the child by inflicting serious bruising or wounds is not acceptable in Arabic discipline.

In general, the well-being of the child is of concern and the fulfillment of educational and economic needs of the child is considered of great importance. In early childhood, the child is predominately trained and disciplined by the mother, who sometimes spansks the child for misbehavior. The authority of the father begins to manifest itself more strongly as the child grows older. Once the child is about age seven, it is the father who becomes the most important disciplinarian in the child's life. The child learns from an early age to obey and respect the parents and other elderly people in the family.

The children are taught a system of etiquette called *adab*, which is a set of expected behaviors that, when fulfilled, earns the child the approval of being *adib* (well mannered). Under this system, children are taught to obey their parents and respect their elders. The child is expected to rise and offer his/her seat to an older person, to talk in a respectful manner, and to kiss the hand of the elder when introduced to him. Generosity is an important behavioral norm transmitted to children. Emphasis is also placed on bravery for male children. Children are expected to courteously greet everyone that they meet regardless of whether the person is known. The phrase used in this respect is "*as-salaamu alaykum*" (peace be upon you) which is answered with "*wa alaykum as-salaam wa rahmatu Allah wa barakatuh*" (and upon you peace and God's mercy and blessings). Males greet males, older women, and their acquaintances among younger females. Females greet females, older men, and their acquaintances among younger males.

In traditional Arab society the basic socialization aim pursued by the family, whether consciously or not, is to mold the child into an obedient member of the family group, able to integrate into the working of his immediate social environment. The growing child has to learn to subordinate his wishes to his family. He has to learn that the interest of the family comes first, and has to govern his actions with the family point of view in mind (Hammad, 1989).

The sex impulse in both men and women is strictly suppressed before marriage. Sexual relations outside of marriage are considered a great social ill and a behavior that is divisive and

undermines societal stability. As such, premarital and extra-marital sexual relations are considered highly shameful and blameworthy. Girls are expected to be virgins (physically intact) at their marriage. If either a man or woman is found to be unchaste, harm and shame comes to that individual and his/her family. Emphasis on sexual abstinence among girls is greater than among boys, as the girl's dignity normally represents the honor of her family.

While rates of pre-marital sex are very high in the general U.S. population, rates of pre-marital sex are quite low for Arabic youth. Because this is such a forbidden issue the health practitioner should take great care to ensure that a question regarding sexual behavior is absolutely necessary before it is asked. On one occasion a pediatrician asked his adolescent patient, a 14 year-old, Arab girl, if she had sex. The mother, upon hearing this question became irate at her daughter thinking that because the doctor asked this question he must believe that she had intercourse. It took several days to calm the family and the girl was still obviously upset. Even if the adolescent patients are alone, questioning about sex may be psychologically disturbing to the individual if they are unmarried.

Although Islam, the established religion of the community, allows a man to marry more than one wife at a time, few people practice plurality in marriage. Polygamy is the exception, not the rule in the Arab community. One of the most important factors that motivates a man to take a second wife during his lifetime is the first wife's inability to produce children. In exceptional social circumstances, the man may take a widowed woman as a second wife to provide for her security.

Time and Social Interchange

It is important for the health professional to understand the Arab context of time and space, in order to respect the patient's perspective. The general pace of Arab social interaction tends to be slower and unhurried. Arab norms stress the importance of politeness and generosity in social interaction. Within this politeness is a well-developed system of etiquette for greetings and establishing new acquaintances. It is important for a health professional not to rush his or her contact with the Arab client. In fact, if a person wishes to rush a social transaction, the person will often be told "do not worry" or "do not be nervous". When a person visits an Arab home, the host is expected to greet the visitor in a most friendly and hospitable way. Commonly, the person is told *wahlan wa sahlan* meaning you are among your own people and (treading upon) common ground (Hammad, 1989). Gifts, food, and coffee are commonly exchanged and viewed as socially obligatory. If offered food or drink, a visitor should accept the offer with gratitude and consume it in its entirety.

On invitation to the home of an Arabic family the visitor is not expected to bring a gift though it is appreciated. The visitor should expect to drink coffee during his or her stay and may receive a gift before his or her departure. The visitor may feel uncomfortable receiving a gift as they are often things that were admired by the visitor while in the home. A person may say "that's a nice statue" and then be offered that statue later at which point it would be offensive to the family if the visitor refused to accept the gesture. Thus, one should be careful on how to express admiration.

This culture difference in expressing admiration need also be considered in admiring children or the spouse of an Arab individual. Whereas a pediatrician often says, "what a beautiful child" to complement the parents, that may potentially be taken as to exhibit improper, sexual connotation. A more appropriate comment would be, "what a nice child" or "you have a very nice wife" with regards to a spouse, which would be taken in a positive manner by the individual.

An outside health professional should seek to establish a relationship of trust with the entire family, not just the patient. A common attitude within hospitals is that the family is an obstructive burden to the patients' care. For Arab patients, it should be understood that the family's presence is highly emotionally supportive and important. Therefore, the health professional should make efforts to address both the patient and the family in interactions and should seek to develop their trust. Such a trust is not readily developed, but generally withheld from Arabs until they view the outsider's character. Once this trust is developed, however, the family can play an important supportive role in health therapy and place much weight on the physician's opinion.

Some consideration of the Middle Eastern context should be taken in order to understand current norms of Arab Americans. While many Arabs have immigrated to the United States as professionals seeking economic opportunity, a number of communities are essentially refugees. In the Dearborn Southend community, for example, the bulk of residents are forced emigrants from war and social upheaval in the Middle East. Many were previously agricultural workers living in simple rural situations. High rates of illiteracy and low educational achievement are observed within that population. Moreover, many have been forcibly separated from their family, and they still must support the family left behind in war situations. Economic pressure bears heavily on these individuals.

The rural existence in the Middle East is much less technological than encountered in the United States. Unintentional injuries might be expected in the United States to some extent from the lack of familiarity with new technology. Also, due to linguistic barriers, many are unable to read instructions for machines or to read pharmaceutical instructions.

Daily life tends to be very physically active in the Middle East. People commonly conduct their daily activities by foot and walk to visit neighbors and family. Agriculture is a predominant form of livelihood that requires physical labor from dawn to dusk. In transition to American life, many Arabs find themselves much less active than previously. Physical activity tends to be low among these immigrants and the idea of exercising for its own sake seems strange and foreign. Because of cultural modesty values, men and women tend to feel shy to exercise outside or in a mixed sex atmosphere, and few sex-segregated facilities exist for them.

Diet similarly changes in transition to American society. Many Arabs live on a diet that is largely seasonal in the Middle East. They consume a high fiber intake of fruit and vegetables locally grown in the summer and dried beans and pulses in the winter. Meat is considered a luxury and is consumed infrequently. After immigration, many Arabs find much greater access to meat and tend to consume it more often. They also encounter foods that are more often processed and high in fat. This is predictive of rising rates of diabetes, cardiovascular diseases, and certain cancers that did not previously affect these individuals.

Birth and Death

Among Arabs, both birth and death are usually met with great community and family participation. Within both Islamic and Arab cultural norms, these two occasions are events in which support from the extended family unit and broader community are expected.

Arabs in the state of Michigan have the highest recorded natality rates of any sub-population in the state. A state statistic established Michigan's Arab American women's average total fertility rate (TFR) is over 2.5 and though this is high within the American context, it is significantly lower than the TFRs seen in many Arab nations where the number of offspring per family ranges from 4-7 children on average. Within Arab culture, there are a number of supporting factors associated with this observed high natality. As explained previously, children

are considered the foremost source of social security and stability for the parents in old age. Within Islam, there is a tradition that "every baby comes with his own provision". This is supported by the Qur'anic verse (17:242) that states: "Do not abandon your children out of fear of poverty, We will provide for them and for you". This is consistent with the view that every event for the individual from birth to death relies on God's will. Such a conception tends to deter the use of birth control and subsequently increases the natality rate, though within Islamic legal interpretation the use of some forms of birth control is allowed. In general, both birth and death are not planned for because this is viewed as taking the will of God for granted.

Within Arabic culture, there is strong pro-natality. Respect is conferred on the individual by having a large number of successful children. For the women, the first birth is viewed as an important initiation into womanhood. The position of mother holds a great amount of respect among the Arabs. A tradition of the Prophet Muhammad states that "heaven is underneath the feet of mothers".

The women during the prenatal period are strongly supported by the surrounding family unit. Numerous family members will participate in ensuring the women's proper nutrition and offering advice. Smoking and alcohol consumption are strongly looked down upon during the pregnancy. The more traditional Arab women are not likely to participate in a hospital/health care provider mixed male/female prenatal education class. Health care providers must know that these traditional women do not mix with men in non-emergency circumstances.

Birth is normally considered a strictly feminine experience and lack of male participation in this experience (i.e. in the labor room) is normal and does not imply negligence. The typical supporting participant for the woman in delivery is the mother, sister, sister-in-law, or mother-in-law. For these expecting mothers appropriate partners for birthing classes would be these female relatives. Because of sex separation issues, a birthing class where any men were present would be uncomfortable for many Arab women. In pregnancies where the father would like to help his wife during the delivery classes may have to be done in a one-on-one fashion or the couple could be left alone to learn with the aid of a birthing video in the Arabic language.

Modesty is an important consideration in the birth space. Many Arab women are extremely uncomfortable delivering without clothes. Families might request the hospital to provide a female ob/gyn to supervise the delivery; this implies that those families do not wish to have any male staff in the birth room. Health care providers should ask Arab American clients of this preference and make prior arrangement to provide a female-only team (for both Arab Muslims and Arab Christians).

The mother and child in the post-natal period are additionally supported by a number of family and community members. Breastfeeding is traditionally encouraged within Arab societies. Islam exhorts women to breast feed her child for two years. In the post-colonial period, Western advertising promoted the idea that infant formula was more beneficial to the child, and perceptions of formula feeding became associated with cosmopolitan living among urban residents.

Death is considered the point at which the individual's actions in this life are sealed and sent forward to the afterlife for judgment. For Muslims, prolonging a person's life in this world with no possibility of further action is seen as futile and an interference with the person's passing to judgment. Islam's legal position on life support is neutral, but it is probably discouraged after the possibility of recovery is diminished. Death is not prepared for with prior funeral arrangements and for a physician to suggest that preparations should be made before a patient dies is viewed as incompetence on the part of the doctor and interference in God's will. At the

death of a patient, it is considered disrespectful for the health care professional to bypass the elder figure of the family and inform a spouse or other younger members of the family unit.

Arabs view the dead as having returned to God. The tradition exhorts Muslims to bury the dead quickly and with utmost respect and dignity (Note: Many Christian Arabs also bury their dead quickly- often on the third day in commemoration of the concept of the resurrection). At the time of death in a Muslim family, witnesses may encourage the dying patient to recite the *shahadatan* (testimony of faith) and may read Qu'ran over the individual. At death, the body is cleaned and perfumed by the family and wrapped in a simple white garb. This simple preparation is symbolic of the fact that Muslims believe that at birth and death, every human is equal, coming to the world with no possessions and leaving with nothing but the record of their deeds.

Autopsies are often refused and Arabs consider them disrespectful to the dead. An Arab family will tend to react with hostility toward pressure from physicians to consent to an autopsy and will become more suspicious with additional pressure. Embalming is only consented to if the body is to be flown overseas for burial. Cosmetic preparation of the body is not considered acceptable. Muslims often prefer not to die in the hospital due to fear that they will not receive proper funeral (*janaza*) treatment. This *janaza* includes the requirements of burying the dead with utmost respect as close as possible to the same day of death with washing, perfuming (*attar*), visitation of the dead by family and community, and group participation in their burial.

Death is an occurrence that is viewed as a community obligation in which all community members that are aware of the death must participate. Health care providers should expect a number of people to be present after the death of the patient and these individuals will want to remain with the body and assure a prompt release from the hospital for preparation and burial. Feelings are very vocally and openly expressed after death, but not before. People stay with the body until it is ready for transportation from the hospital. They begin the grief process by counseling the deceased's closest relatives. Wailing and gasping is a common reaction in grieving. If the patient who dies is young, the grieving process requires more time and significance. The death of young parents who leave small children behind is particularly traumatic with the loss of the children's primary support system. Similarly, the death of a child is a tremendous loss that is surrounded by extensive grieving.

The concept that Arabs value life less than Americans is an incorrect stereotype. However, there is a different world view and a greater acceptance of the will of God. All events *kharyun ow sharr*, happen according to the will of God. Part of being Muslim is submission to the will of God and acceptance of fate. Sickness is also the will of God. The day of your death is written for you at birth and all of life happenings are written on the Preserved Tablet. However, Arab people are also pragmatic. There is an old Arabic saying: "trust in God but tie your camel first".

REFERENCES

- Abraham, S.Y. and N. Abraham.1981. The Arab World and Arab Americans: Understanding a Neglected Minority. Detroit: Wayne State University Center for Urban Studies
- Abraham, S.Y. and N. Abraham.1983. Arabs in the New World: Studies on Arab-American Communities. Detroit: Wayne State University Center for Urban Studies
- ACCESS Cultural Museum. 2651 Saulino CT., Dearborn, Michigan. Open for viewing during most regular business hours.
- Al-Qudsi, S. "The Health Sector of a High Fertility Region: The Arab World", in Teebi, A.S., Farag, T.I., eds. Genetic Disorders Among Arab Populations., 1997. New York: Oxford University Press.
- Deeb, M.E. and Sayegh, L.G. "Population Dimensions in the Arab World", in Teebi, A.S., Farag, T.I., eds. Genetic Disorders Among Arab Populations., 1997. New York: Oxford University Press.
- Good B. and M. Del Vecchio Good 1982. "Patient requests in primary care clinics", In N.J. Chrisman and T. W. Maretzki eds. Clinically Applied Anthropology., Boston: D. Reidel.
- Helman, A. G. 1997. Culture, Health, and Illness. Third Edition. Boston: Butterwoth Heinemann.
- Hahn, R. A. 1995. Sickness and Healing: An Anthropological Perspective. New Haven and London: Yale University Press.
- Hamarneh, S. K. 1983. " The Life Sciences" In The Genius of Arab Civilization: Source of the Renaissance. Second Edition. J.R. Hayes. Editor. Cambridge: The MIT Press pp. 173-200.
- Hammad, A. 1989. Effectiveness and Efficiency in the Management of Palestinian Health Services. Ph.D. Thesis. University of Manchester. Jan. 1989.
- Hassoun, R.J.1995. A Bioanthropological Perspective of Hypertension in Arab-Americans in the Metropolitan Detroit Area. Dissertation. University of Florida, Gainesville. UMI Microfiche.
- Ingstad, B. and S. R. Whyte. 1995. Disability and Culture. Berkeley: University of California Press.
- Johnson, in Michigan Department of Public Health, 1995. Minority Health in Michigan. Lansing: Michigan.
- Kleinman, A. 1981. Patients and Healers In the Context of Culture. Berkeley: University of California Press.
- Kulwicki, A. 1990. Cardiovascular and Diabetes Survey.
- Michigan Department of Public Health, 1988. Minority Health in Michigan: Closing the Gap. Lansing: Michigan.
- Naff, A. Becoming American: The Early Arab Immigrant Experience , 1985. Carbondale and Edwardsville: Southern Illinois University Press.
- Savoie, C., 1995. Environmental Health Director of ACCESS.
- Teebi, A.S., 1997. "Introduction", in Teebi, A.S., Farag, T.I., eds. Genetic Disorders Among Arab Populations., 1997. New York: Oxford University Press.
- United Nations Development Program (UNDP) 1993: Human Development Report. Investing in Health. Oxford University Press, New York.

Appendix A: Other Salient Background Features Related to the Middle East

A Primer of Concepts

a. **'ayb** : The role of shame in motivation of Arab behavior. Individuals are inseparable from their family unit in the Arab world and the family is the ultimate source of allegiance and the ultimate measure of success. Disease is considered a mark of imperfection or weakness that reflects on the entire family even to the extent that family members might be unmarriageable. Disabilities and mental disturbance are the most prominent elicitors of *'ayb*-oriented behavior. Arab culture holds an expectation of perfection, particularly physically.

b. **perception of mental illness**--punishment from God for the sins of the individual or his family, touched by *jinn* (usually perceived as malevolent spirits), or ridden by the devil. Mental illness is shunned. It is not uncommon to see a reluctance to send a disturbed family member to an asylum or for treatment out of desire not to recognize and disclose the problem.

c. **non-recognition of chronic disease**--stigma, *'ayb*-oriented. Chronic diseases like cancer, diabetes are considered hereditary and reflect on the whole family. There is also a fear of reducing the marriageability of children by disclosure of these kinds of illnesses.

d. **belief in unseen forces**: Arabs from the Middle Ages theorized about the germ theory and it is well established within our consciousness. However, there is also an acceptance that unseen forces may cause disease such as *jinn*, by the evil eye. While *jinn* are feared as malevolent and capricious spirits that may cause illness and other evil, the evil eye can best be understood in the context of fearing the envy of others which may also be the cause of sickness or even death.

e. **deep seated respect for age and expertise**-- respect increases with age and authority. Doctors do receive a great respect and trust. Arab patients submit to that authority without questioning. This contributes to the low rate of medical-legal cases among Arabs. Perception that the doctor is incompetent or not trustworthy will not result in an open confrontation/discussion with the doctor, but instead will result in noncompliance with his directions.

f. **alternative healing**: a long tradition of treatment exists in the Arab world. The Arabs have a system of healing tradition that is over 3,000 years old, including herbalism and conception of the body as a unified system composed of interacting humors. While the Western approach is to look for the smallest particular cause, the Arab system looked for the imbalance in the body as a whole. Problems like gastrointestinal disorders, fevers, headaches, orthopedic difficulties, and fractures all have a well-established traditional approach for their alleviation. Bonesetters are considered better than orthopedic doctors in the Middle East. Traditional midwives are well skilled in the Arab World.

g. **concept of time**: In Arab culture, time is not linear and is not constricted in the way that it is in the West. Not tomorrow at 9:30AM but *insha 'Allah*" (God-willing) I'll see you before lunch. Lateness is accepted and anger about it is not understood.

h. **Arab family structures:** Extended family structure is the most common form for Arab families. There are four types of family organization: nuclear (mother, father and children found in the minority of Arab households), extended (which may also include grandparents, aunts, uncles, and cousins), *hammula* (3-4 extended families) and *qabila* (4-5 *hammulas*).

i. **role of the family in decision making:** The consideration of the welfare of the family takes precedence over individual considerations. Indeed, the American focus on individuality is seen as verging on pathological behavior in the Arab world. Because of the supremacy of the family, decisions are more likely to be made collectively in Arab families. Both the considerations of the family and the individual are carefully weighed. Older males, the patriarchs, of families may be asked to make health decisions for an individual family member. This role of the family complicates informed consent and confidentiality issues.

j. **position of men, women, children, elderly in the family--**men's power and influence is in the external realm, while women control the internal matters of the household. Elderly enjoy final power and respect for consultation and guidance. Children are not participants in family decisions and are expected to be obedient to the family elders.

k. **marriage:** Premarital sexual relations are considered shameful, dirty, and sinful. Marriage is a prerequisite for respect and consideration as a mature member of the society.

l. **health risk behavior:** smoking, diet, exercise--Arab culture is supportive of many risk behaviors that are not considered within the context of good health. Smoking is considered both part of manhood and of generosity. Cigarettes are offered like tea and coffee as a matter of hospitality. The Arab diet in the Arab World is considered to be healthy with a tendency toward high fiber, lots of fruit and vegetables, and fresh daily preparation of food. Meat is emphasized as good, but is generally restricted by cost. It is not a part of Arab consciousness to consider diet as a contributor to bad health. Similarly, Arab lifestyle is active due to the nature of life activities (70% rural, family visits, and walking).

Consequently, aerobics and exercise machines are considered foreign and silly. However, after immigrating to the United States, The Arab diet and lifestyle changes. The consumption of meat, snacks, fat, and sweets increases while the amount of exercise declines leading many Arab Americans, especially the elderly, to suffer from obesity, high cholesterol, and other related illnesses (Hassoun 1995).

m. **primary health care access in the Middle East and preventive service utilization:** health services and education are free and accessible in the Arab countries, but quality varies. This is why the rate of medical insurance is very low, since it is not thought of as a requirement for health care. Medical services are generally only sought when the individual is acutely sick. A doctor who does not perform some invasive procedure (injections, clinical tests) or does not prescribe medications is considered incompetent.

n. **political and social background:** organizational structures and affiliation--Arabs in the United States have a variety of national differences compounded with a wide variety of political, social and religious underpinnings. Also, social stratification exists along class and urban/rural/refugee camps.

Appendix B: Arabic Phrases

Ahlan wa sahlam	Welcome (greeting)
Marhabah	Hello
Keef Halak	Hello, How are you?
Mabsut	Good (Happy)
Mneeh, wa ente	Fine, and you?
Esmee...	My name is ...
Naam	Yes
Lah	No
Shukran	Thank you
Afwan	You're welcome
Maa al salama	God-Bye
In'sha Allah	God-willing

Appendix C: Tables

Table 1. Health Statistics from the Arab World

Country	Life Expectancy at Birth (1990-94) ^a	IMR (1990-1994) ^a	TFR (1990-1994) ^a	GNP per Capita (1990) (US\$) ^b	Total Illiteracy (%) ^b	Female Illiteracy (%) ^b	Population (millions) (1991) ^b	Urban (%) (1991) ^b
Algeria	67.5	54	4.19	1,980	55	43	25.6	52
Bahrain	74.4	23	5.38	7,130	31	23	0.5	83
Djibouti	49.0	112	6.50	1,210 ^c	--	--	0.5	81
Egypt	66.0	68	4.87	610	66	52	53.6	47
Iraq	65.2	63	5.83	2,140	51	40	18.7	71
Jordan	67.9	34	5.87	1,050	30	20	4.1	68
Kuwait	78.3	9	5.96	16,160	33	27	2.1	96
Lebanon	75.9	28	2.99	2,150	27	20	2.8	84
Libya	63.1	68	6.66	5,310	50	36	4.7	70
Mauritania	48.0	117	6.50	510	79	66	2.1	47
Morocco	67.2	66	3.59	1,030	62	51	25.7	48
Oman	65.0	54	6.42	6,120	--	--	1.6	11
Qatar	72.0	21	5.54	14,770	--	--	0.4	89
Saudi Arabia	69.0	56	6.85	7,820	52	38	15.4	77
Somalia	47.1	122	6.60	120	86	76	8.9	36
Sudan	51.8	99	6.26	420 ^c	88	73	25.9	22
Syria	63.6	44	5.56	1,160	49	36	12.8	50
Tunisia	67.8	36	3.18	1,500	44	35	8.2	54
United Arab Emirates (UAE)	75.0	22	5.99	20,140	--	--	1.6	78
West Bank and Gaza	68.7	33	7.82	--	--	--	1.6	51
Yemen	49.0	117	8.62	520	74	62	12.1	29
Total	63.4	68	5.37	--	--	--	228.9	59

IMR – Infant Mortality Rate; TFR – Total Fertility Rate; GNP – Gross National Product

- a- Courbage and Khlal [1993] in Deeb and Sayegh, 1997.
- b- UNDP, World Development Report [1993] in Deeb and Sayegh, 1997.
- c- UNICEF, State of the World's Children [1994] in Deeb and Sayegh, 1997.

Table 2. Median Age at Marriage by Age Categories in Arab Countries

Country	Year	Age Bracket					
		20-24	25-29	30-34	35-39	40-44	45-49
Bahrain	1989	--	22.5	19.9	17.9	15.6	14.8
Egypt	1991	20.3	19.0	18.4	18.0	17.6	17.1
Jordan	1990	--	21.2	19.7	18.8	18.9	18.9
Kuwait	1987	--	19.1	18.7	18.0	17.3	17.1
Morocco	1987	--	19.9	18.9	18.1	16.8	16.3
Oman	1988	16.2	15.7	15.6	15.2	15.0	14.7
Qatar	1987	--	21.4	18.0	16.6	16.5	15.9
Saudi Arabia	1987	20.3	18.1	17.2	16.5	16.5	16.6
Sudan	1989-90	--	20.5	18.1	16.4	15.8	16.3
Tunisia	1988	--	22.8	21.3	20.6	19.4	19.9
United Arab Emirates (UAE)	1987	21.0	17.7	16.8	16.3	16.0	16.2

Source: Al-Qudsi, S. (1997)

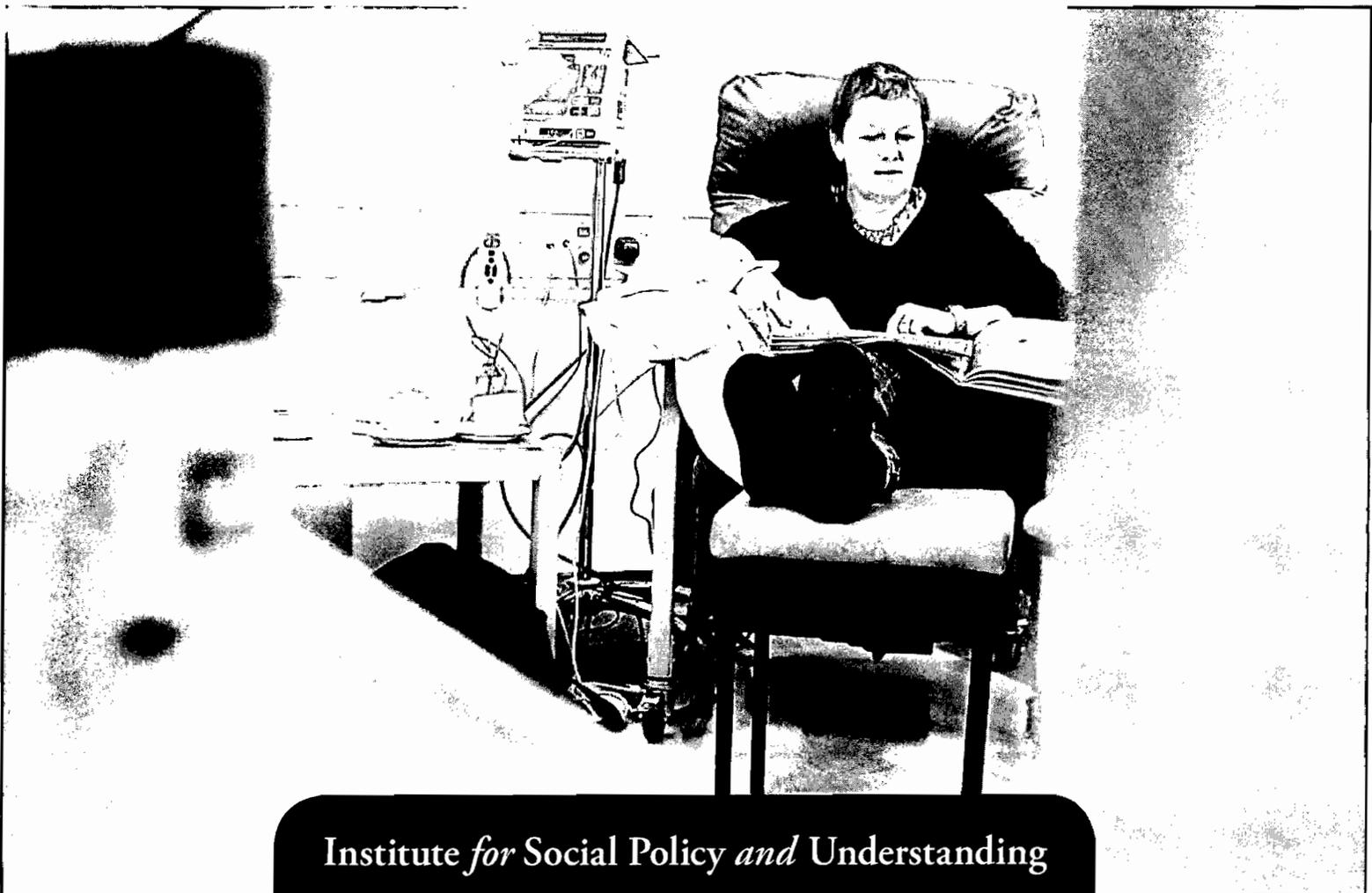


JUNE 2011
REPORT

ISPU

MEETING THE HEALTHCARE NEEDS OF AMERICAN MUSLIMS: Challenges and Strategies for Healthcare Settings

Aasim Padela, MD, MS, Katie Gunter, MPH, MSW, & Amal Killawi, MSW



Institute for Social Policy and Understanding



© 2011 Institute for Social Policy and Understanding. All rights reserved. No part of this publication may be reproduced or transmitted in any form or by any means without permission in writing from the Institute for Social Policy and Understanding. The Institute for Social Policy and Understanding normally does not take institutional positions on public policy issues. The views presented here do not necessarily reflect the views of the Institute, its staff, or trustees.

About The Authors

Aasim Padela, MD MS

ISPU Research Fellow

Aasim Padela is an ISPU fellow and an emergency medicine physician with bachelor degrees in biomedical engineering and classical Arabic & literature. He attended Weill Cornell Medical College and completed his residency at the University of Rochester. Dr. Padela is currently completing his final year in the Robert Wood Johnson Clinical Scholars Program, where his research focuses on healthcare inequities and cultural barriers to care for American Muslim and Arab-American populations. In addition, he is a visiting fellow at the Oxford Centre for Islamic Studies (2010-11) working on an ethical framework for transnational global health initiatives and theoretical and applied Islamic bioethics. This summer Dr. Padela will be joining the faculty of the University of Chicago in the Program on Medicine and Religion, Maclean Center for Ethics, and the Section of Emergency Medicine.

Katie Gunter, MPH MSW

Research Assistant

Katie Gunter is a research assistant at ISPU where she contributes to grant writing and disseminating research. Ms. Gunter also works at the University of Michigan's Department of Internal Medicine and with the School of Public Health's Center on Men's Health Disparities. Her research interests include community-based participatory research (CBPR) and factors that differentially influence health, health behavior, and healthcare quality, as well as their relationship to racial and ethnic health disparities, particularly with regards to disparate patterns of health and illness among men. She has worked with non-profit organizations and in healthcare settings focused on providing healthcare to underserved populations. Ms. Gunter completed her MPH and MSW at the University of Michigan.

Amal Killawi, MSW

Research Assistant

Amal Killawi is a clinical social worker and research associate at the University of Michigan, where she works at the Department of Family Medicine and with the Robert Wood Johnson Foundation. Ms. Killawi served as the project manager for this study, acting as a community liaison and contributing to data collection, data analysis, and dissemination of research. As a long time community activist, she has worked with various non-profits, particularly focused on mental health and marriage and family life education. Her research interests include community-based participatory research (CBPR), health disparities, and culturally competent care. Ms. Killawi completed her Bachelor's in Psychology and Master's in Social Work at the University of Michigan.

Acknowledgements

This study was funded by the Robert Wood Johnson Foundation Clinical Scholars Program and the Institute for Social Policy & Understanding. We thank our respondents for sharing their time and insights with us, as well as our community partners and steering committee members for their support and invaluable recruitment assistance: Muzammil Ahmed MD, Hamada Hamid DO MPH, and Shireen Zaman MA (all from the Institute for Social Policy & Understanding); Najah Bazy RN (Islamic Center of America); Adnan Hammad PhD (Arab Community Center for Economic & Social Services); Mouhib Ayyas MD (Islamic Shura Council of Michigan); and Ghalib Begg (Council of Islamic Organizations of Michigan). We also express gratitude to our academic mentors and collaborators for assistance throughout the project: Michele Heisler MD MPA (the Robert Wood Johnson Foundation's Clinical Scholars Program), Michael D. Feters MD MPH MA (Department of Family Medicine, University of Michigan) and Sonia Duffy PhD RN and Jane Forman ScD, MHS (both from the VA Ann Arbor Healthcare System). We also thank Amanda Salih MPH and Heather Tidrick MSW for helping to code manuscripts and qualitative data analysis. Lastly, a note of thanks to our troupe of research assistants, namely, Afrah Raza, Shoaib Rasheed, Ali Beydoun, Nadia Samaha, David Krass, Imen Alem, and Samia Arshad MPH, for their invaluable assistance.

Table of Contents

5	Executive Summary
6	Introduction
7	Conceptual Model
8	Methodology, Setting, and Study Participants
9	Data Analysis
11	Beliefs about Health and Healing
13	The Need for Cultural Competence
15	Priority Healthcare Accomodations
16	The Role of Imams
20	Challenges in Providing Culturally Sensitive Healthcare
22	Recommendations
25	Conclusion

Executive Summary

The Islamic values and cultural practices of American Muslims can play a role in community health disparities by influencing health behaviors and healthcare-seeking patterns and presenting challenges within the healthcare system. To date, scant empirical research has been conducted in collaboration with this community in order to better understand their beliefs and perceived challenges. This report is based on the analysis of qualitative data from semi-structured interviews and focus groups collected through a community-based participatory project with American Muslims living in southeastern Michigan. Specifically, our aim was to (1) identify key health beliefs and practices within the community, (2) gain a better understanding of these beliefs and practices and how they may impact the seeking of healthcare services, and (3) identify clinical situations that pose cultural challenges within healthcare. This report provides an overview of American Muslim health beliefs, describes how these beliefs impact healthcare-seeking practices, and recommends accommodations that can improve the healthcare experience of American Muslim patients. Understanding the links between Islamic beliefs and practices and their influence on clinical encounters provides opportunities to improve community health and deliver culturally sensitive high quality care.

Introduction

Research has demonstrated that minority patient populations receive a lower quality of care and face significant challenges when trying to access and receive healthcare.¹ Among racial and ethnic groups, health disparities persist due to the confluence of structural, institutional, and interpersonal factors.¹ Overcoming these barriers and disparities requires that the beliefs, priorities, and healthcare needs of minority communities be understood and accommodated. Health disparities among religious minorities merit particular consideration, as religious values are very influential in an individual's and group's development and articulation of the concept of "health." Thus, a better understanding of how religious values influence health behaviors can result in the delivery of more culturally sensitive healthcare services.

American Muslims are a fast-growing, under-studied, and underserved minority. While ethnically and racially diverse, they are bound together by a shared religious tradition that shapes their worldview and informs their behavior. The major ethnic groups within the American Muslim community are indigenous African Americans, South Asians, and Arabs.²⁻⁷ American Muslims may share religiously informed views on health, illness, and the healing process. For example, many aspects of healthcare may be informed by individual and personal practices of Islam- from conceptions of disease and cure to healthcare-seeking patterns and decision-making. When considering the healthcare needs of American Muslim patients, providers must be aware of the wide spectrum of adherence, religious practice, rituals, and traditions within this community. Nonetheless, areas of shared concern between different segments of this population exist and are the focus of our project.

Increasing cultural competence has been cited as part of the solution to reduce health disparities; however, "Muslim patient cultural guides" are predominantly based on provider experiences as opposed to empirical research conducted in collaboration with the community.^{8,9} To better understand the factors that influence American Muslim health barriers and challenges, we embarked on a community-based participatory research project. This report presents an overview of American Muslim health beliefs,

Research has demonstrated that minority patient populations receive a lower quality of care and face significant challenges when trying to access and receive healthcare.

1 Smedley BD, Stith AY, Nelson AR, Institute of Medicine (U.S.). Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Unequal treatment: confronting racial and ethnic disparities in health care. Washington, D.C.: National Academy Press; 2003.

2 Muslims American Demographic Facts. <http://www.allied-media.com/AM/>. Accessed January 19, 2010.

3 American Muslims: Population Statistics: Council on American-Islamic Relations; 2005.

4 Ba-Yunus I. Muslims of Illinois, A Demographic Report. Chicago: East-West University; 1997.

5 Obama B. Remarks by the President on a New Beginning. Cairo, Egypt; 2009.

6 Smith TW. The Muslim Population of The United States: The Methodology of Estimates Public Opinion Quarterly. 2002;66:404-417.

7 The World Almanac and Book of Facts 2001: World Almanac Books; 2001.

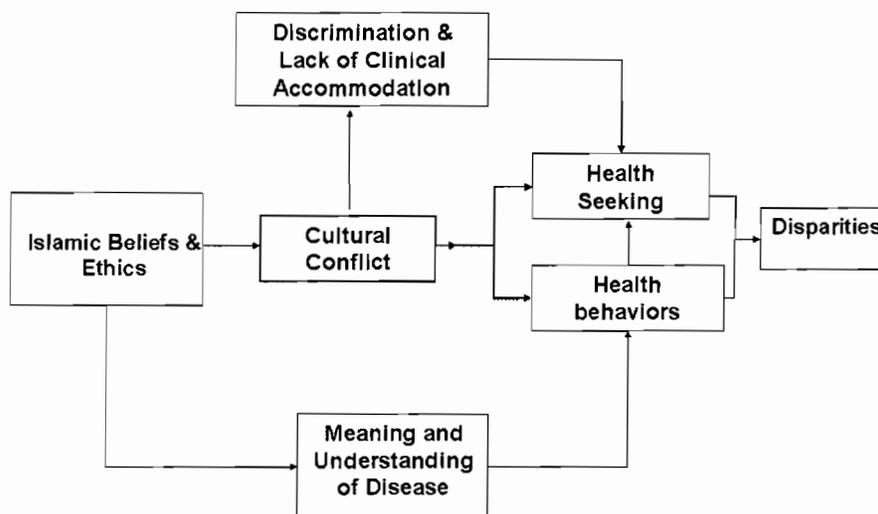
8 Markova T, Broome B. Effective communication and delivery of culturally competent health care. Urol Nurs. Jun 2007;27(3):239-242.

9 Miklancic MA. Caring for patients of diverse religious traditions: Islam, a way of life for Muslims. Home Health Nurse. Jun 2007;25(6):413-417.

describes how these beliefs impact healthcare-seeking practices, and recommends accommodations that can improve the healthcare experience of American Muslim patients.

CONCEPTUAL MODEL

For this study, a conceptual model was synthesized from multiple theoretical models in the medical literature. Kleinman's model of the cultural construction of clinical reality portrays patient-doctor interactions as transactions between competing explanatory models of disease and illness and thus may involve discrepancies in therapeutic goals and values.¹⁰ This model provides the foundation for understanding how Islam influences Muslim patients' cultural construction of disease and illness, as well as the meanings attached to therapeutics. The Institute of Medicine's seminal report entitled "Unequal Treatment" cites prior experiences of discrimination, bias, and mistrust of the healthcare system as factors that influence health and healthcare-seeking behaviors. The authors posit that these mechanisms play a role in healthcare disparities of Muslim patient populations. Leininger's cultural care theory notes that patients who experience healthcare that is not reasonably congruent



with their beliefs and values may show signs of cultural conflict and/or ethical concern. As a result, the healthcare dynamic may be fraught with non-adherence and tension.¹¹ Together these portions

¹⁰Kleinman A, Eisenberg L, Good B. Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. *Ann Intern Med.* Feb 1978;88(2):251-258.

¹¹Wehbe-Alamah H. Bridging generic and professional care practices for Muslim patients through use of Leininger's culture care modes. *Contemp Nurse.* Apr 2008;28(1-2):83-97.

were synthesized into a conceptual model that guided our process of developing interview guides and shaped our approach to data analysis.

Examples that highlight pieces of our conceptual model include the potential challenge of maintaining cervical health for a Muslim woman who may believe that her illness is a test from God and an atonement for her sins. Believing that God has predestined her illness and form of death, she may delay or refuse medical treatment. Another Muslim may distrust western medicine and rely upon such alternative Muslim therapies as holy water, herbal treatments, and prayer. Thus, he may not seek medical care or adhere to the recommended therapies. A Muslim woman may seek healthcare services only from a female gynecologist. If her health plan does not list one, she may choose to postpone or avoid healthcare visits and thus not receive a pap smear for cancer screening. All of these scenarios exemplify healthcare-seeking or health behaviors that may influence healthcare disparities within this community.

METHODOLOGY, SETTING, AND STUDY PARTICIPANTS

Southeastern Michigan is home to one of the United States' longest standing and largest Muslim American communities estimated to number, around 200,000 individuals.¹²⁻¹⁴ We used a community-based participatory research design in partnering with four key community organizations: the Institute for Social Policy and Understanding (ISPU), the Arab Community Center for Economic & Social Services, and two Islamic umbrella organizations representing more than thirty-five Muslim institutions including over twenty-five mosques; the Islamic Shura Council of Michigan and the Council of Islamic Organizations of Michigan.

Members of these organizations, along with an interdisciplinary investigative team, formed part of the steering committee that guided all of the project's phases, from research question and interview guide development to participant recruitment, data analysis, and dissemination.¹⁵ The interdisciplinary investigative team included a Muslim physician-researcher with expertise in Islamic bioethics and experience as an imam and volunteer healthcare chaplain, a social worker active in Muslim advocacy organizations, an experienced qualitative researcher, a senior health services researcher, a nurse-investigator with research experience within the American Muslim community, and several individuals with public health backgrounds. The project, approved by the University of Michigan's Institutional Review Board, consisted of two phases.

Southeastern Michigan is home to one of the United States' longest standing and largest Muslim American communities, estimated to number around 200,000 individuals.

12 Hassoun R. Arab Americans in Michigan. East Lansing: Michigan State University Press; 2005:1-17.

13 Numan FH. The Muslim Population in the United States. 1992; http://www.uga.edu/islam/muslimpop_usa.html. Accessed January 27, 2010

14 Michigan. Arab Americans 2003; http://www.aaiusa.org/page/file/f6bf1bfae54f0224af_3dtmvyj4h.pdf/Mldemographics.pdf.

15 Israel B, Eng E, Schultz A, Parker E, Satcher D, eds. Methods in Community-Based Participatory Research in Health. San Francisco: Jossey-Bass Publications; 2005.

Phase 1: Representatives from our partner organizations and steering committee members identified the key informants and community stakeholders to be interviewed and outlined interview protocols and questions. We used a purposive maximum variation sampling method to identify community leaders with a wide variety of experiences and views.¹⁶ Specifically, we attempted to interview both men and women, persons holding various positions within the community (including imams), and persons of different ethnicities, races, countries of origin, and theological branches. During Phase 1, twelve interviews were conducted with community gate-keepers and leaders in order to acquire an initial perspective on Muslim health beliefs and practices, areas of conflict, and challenges within the American healthcare system (Table 1).

Phase 2: Community-based focus groups were conducted at area mosques and segmented by gender and language preference (Arabic vs. English). Sampling was designed to achieve variation on race, gender, and ethnicity as well as to represent the community's main groups (African Americans, South Asian Americans, and Arab Americans). Focus groups explored in great detail the topics that emerged from the semi-structured interviews in Phase 1.

The 13 focus groups (7 female and 6 male) consisted of a total of 102 participants (56 women and 46 men) (Table 2). The number of participants in each focus group ranged from 4 to 12, with a mode of 9 people. Participants ranged in age from 18 to 75, with a mean age of 45 years. Most participants identified as Sunni (N=81, 82%) while 43% of participants were Arab American (N=43), 23% were South Asian (N=23), and 22% were African American (N=22).

DATA ANALYSIS

The detailed content analysis of the data utilized a framework and team-based approach. Analysts immersed themselves in the data by reading and open-coding the transcripts in order to develop a preliminary coding scheme. Disagreements were resolved by team consensus, and emergent themes were discussed via a constant-comparison method during team meetings. Each transcript was assigned to an analyst, who would then develop a summary by code and perform a local integration of codes by grouping them into higher order conceptual themes. These summaries were used in team meetings to perform a global integration of themes across the interviews.¹⁷

16 Patton M. *Qualitative evaluation and research methods*. Beverly Hills: Sage Publications; 1990.

17 Weiss RS. *Learning from Strangers: The Art and Method of Qualitative Interview Studies*. New York: The Free Press; 1994.

Table 1: Participants Characteristics (N=12) in Phase 1

Characteristic	N
Age	
mean (SD), y	44.3 (13.6)
< 30 years	2
30-55 years	7
> 55 years	3
Sex	
Male	7
Female	5
Religious Affiliation	
Sunni	8
Shi'ite	1
Prefer Not To Say	3
Ethnicity	
Arab/Arab American	6
African American/Black	2
South Asian	2
European/White	1
Other	1
Education Level	
Associate degree and/or some college	2
4 year college degree	2
Advanced degree (Masters, Doctorate)	8
Country of Origin	
United States	6
Other	6
Africa	1
Europe	1
Middle East	3
South Asia	1
Primary Role in American Muslim Community	
Imam	2
Leadership Role in Community Health Organization	3
Leadership Role in Community Civic Organization	1
Community Organizer	2
Allied Health Professional	4

Table 2: Demographic Characteristics of the Focus Groups (13 Focus Groups with 102 Participants)

Characteristic	Frequency (N=Focus Groups)
Gender	
Female	7 (54%)
Male	6 (46%)
Ethnicity	
Arab American/Arab	4 (31%)
Mixed	4 (31%)
South Asian	3 (23%)
African American/Black	2 (15%)
Language	
English	12 (92%)
Arabic	1 (8%)

In terms of the agents in healing, multiple studies note that Muslims view God as the sole controller of health and illness.

BELIEFS ABOUT HEALTH AND HEALING

As religious values and beliefs are intricately linked to cultural norms and practices, they shape patients' notions of health and illness, influence expectations of encounters with healthcare providers, affect adherence to doctors' recommendations, guide medical decision-making, and influence health outcomes.¹⁸⁻²² Religion and spirituality also directly affect mental and physical health, for they influence coping strategies, health behaviors, and healthcare-seeking attitudes.²³⁻²⁵ To further explore the role of culture in understanding health, illness, and health behaviors, this section relates how American Muslims view health and the agents in healing. After a brief literature review, we present our findings.

18 Johnson JL, Bottorff JL, Balneaves LG, et al. South Asian womens' views on the causes of breast cancer: images and explanations. *Patient Education and Counseling*. 1999;37(3):243-254.

19 Nielsen M, Hoogvorst A, Konradsen F, Mudasser M, van der Hoek W. Causes of childhood diarrhea as perceived by mothers in the Punjab, Pakistan. *Southeast Asian Journal of Tropical Medicine and Public Health*. 2003;34(2):343-351.

20 Nehra A, Kulaksizoglu H. Global perspectives and controversies in the epidemiology of male erectile dysfunction. *Current opinion in urology*. 2002;12(6):493-496.

21 Fukuhara S, Lopes A, Bragg-Gresham J, et al. Health-related quality of life among dialysis patients on three continents: the Dialysis Outcomes and Practice Patterns Study. *Kidney International*. 2003;64(5):1903-1910.

22 Geertz C. *Local knowledge: further essays in interpretive anthropology*. New York: Basic Books; 1983.

23 Koenig HG. Research on religion, spirituality, and mental health: A review. *Canadian journal of psychiatry*. 2009;54(5):283-291.

24 Larson DB, Larson SS, Koenig HG. Mortality and religion/spirituality: A brief review of the research. *The Annals of pharmacotherapy*. 2002;36(6):1090-1098.

25 Koenig HG. *Religious practices and health: Overview*. 2008.

The extant and largely qualitative literature provides a degree of insight into how American Muslims view health and identifies some of the agents in the healing process. In a study of immigrant Pakistani families, conceptions of health were reported to include the social, spiritual, and physical domains. The authors noted that the acceptance of medical treatments was mediated by a sense of concordance within this holistic conception of health.²⁶ In a similar fashion, Afghan American elders residing in California reported their health as tied to their adherence to Islam and thus utilized various religious practices to heal themselves.²⁷ In terms of the agents in healing, multiple studies note that Muslims view God as the sole controller of health and illness.^{28,29} Johnson and Bottorff explored South Asian women's views on breast cancer and its etiology. Among other causative factors, the women reported that God determines who develops breast cancer and who is cured. Their view that breast cancer was a "disease of fate" influenced their healthcare-seeking behaviors, as some believed that they were destined to suffer, while others felt that their fate could be changed through prayer and seeking medical care.^{30,31} Arab-American immigrants in New York also echoed the beliefs that cancer was from God and that modifiable risk factors were only a secondary concern, thereby giving voice to a potentially fatalistic attitude.³²

Our study also offered insight into how religious beliefs and values influence patients' notions of health, illness, and healing. Our research participants opined that health has multiple components: spiritual, physical, and mental. They stated that in order to move from a state of illness to a state of well-being, multiple agents performed one or more ameliorating functions within one or more of these domains. God was said to have the preeminent role in health, as His decree led to disease and feeling ill and to healing and maintaining one's health. Most participants perceived illness through a religious lens as predestined, a trial from God by which one's sins are removed, an opportunity for spiritual reward, a reminder to improve one's health, and sometimes a sign of personal failure to follow Islam's tenets. Participants also remarked that in addition to prayer and supplicating to God, human agents (e.g., imams, family members, healthcare providers, friends, and community members) played important roles. Each actor is viewed as God's instrument and thus assumes various roles within the healing process.

The imam is a central figure in this process, for he delivers healthcare messages framed within an Islamic worldview, counsels the distressed, provides spiritual support, and facilitates healing through

God was said to have the preeminent role in health, as His decree led to disease and feeling ill and to healing and maintaining one's health.

26 Jan R, Smith CA. Staying healthy in immigrant Pakistani families living in the United States. *Image - the Journal of Nursing Scholarship*. 1998;30(2):157-159.

27 Morioka-Douglas N, Sacks T, Yeo G. Issues in caring for Afghan American elders: insights from literature and a focus group. *Journal of cross-cultural gerontology*. 2004;19(1):27-40.

28 DeShaw P. Use of the emergency department by Somali immigrants and refugees. *Minnesota medicine*. 2006;89(8):42-45.

29 Ypinazar VA, Margolis SA. Delivering Culturally Sensitive Care: the Perceptions of Older Arabian Gulf Arabs Concerning Religion, Health, and Disease. *Qualitative Health Research*. 2006;16(6):773-787.

30 Johnson JL, Bottorff JL, Balneaves LG, et al. South Asian women's views on the causes of breast cancer: images and explanations. *Patient Education & Counseling*. Jul 1999;37(3):243-254.

31 Rajaram SS, Rashidi A. Asian-Islamic women and breast cancer screening: a socio-cultural analysis. *Women Health*. 1999;28(3):45-58.

32 Shah SM, Ayash C, Pharaon NA, Gany FM. Arab American immigrants in New York: health care and cancer knowledge, attitudes, and beliefs. *J Immigr Minor Health*. Oct 2008;10(5):429-436.

communal supplications or prescribing Qur'anic litanies. Within the hospital, his role somewhat overlaps those of healthcare chaplains: he visits Muslim patients, is involved in patient-provider-family healthcare discussions, and serves as a religious "translator" and cultural broker.³³ The family also plays an important role, for its members provide physical care, emotional and spiritual support, and mediate interactions with the healthcare system. Allopathic healthcare providers provide clinical care and are expected to communicate with and educate patients in a respectful manner, as well as facilitate recognition of their religious and cultural traditions. Lastly, friends and community members contribute to the healing process by providing emotional and spiritual support. In this way, the community maintains a holistic vision of healing and recognizes several key agents outside of the allopathic system who influence one's spiritual, physical, and psychological health.

Understanding these perspectives should inform efforts designed to achieve cultural competence and the delivery of culturally sensitive care. At the patient-provider level, the healthcare provider's increased awareness of American Muslim views of healing will help them frame healthcare interventions and enhance partnerships. On a macro-level, healthcare systems and stakeholders can partner with various agents within the healing process to tailor and improve community health interventions. As noted, given that links between Islamic beliefs and practices may affect clinical encounters, culturally sensitive healthcare accommodations should be developed and implemented. As healthcare settings are confronted with adapting to an increasingly racially and ethnically diverse patient population, providers need to respond to a variety of patient perspectives, values, and behaviors about health and well-being. Failure to accommodate the health beliefs and behaviors of American Muslim patients may contribute to healthcare inequalities.

THE NEED FOR CULTURAL COMPETENCE

Cultural competence has been defined as a "set of congruent behaviors, attitudes, and policies that comes together in a system, agency, or amongst professionals and enables them to work effectively in cross-cultural situations."³⁴ Research shows that training in this area can improve the "knowledge, attitudes, and skills" of providers working with diverse patient populations.³⁵ Cultural competence efforts that recognize and accommodate the patients' cultural and religious values can help reduce racial and ethnic healthcare disparities.³⁶ Providing appropriate services can also improve patient

33 DeVries R, Berlinger N, Cadge W. Lost in Translation: The Chaplain's Role in Health Care. *Hastings Center Report*. 2008;38(6):23-27.

34 Cross TL, Bazron BJ, Dennis KW, Isaacs MR. *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed*. Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center;1989.

35 Beach MC, Price EG, Gary TL, et al. Cultural competence: a systematic review of health care provider educational interventions. *Medical care*. 2005;43(4):356-373.

36 Brach C, Fraserirector I. Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical care research and review*. 2000;57(4 suppl):181-217.

health outcomes and increase client satisfaction.³⁷

In our focus group discussions, participants noted the importance of cultural competency among providers and the healthcare system by using the following various terms interchangeably: "cultural sensitivity," "cultural awareness," "education," and "cultural sensitivity training." While explaining the rationale for this need, they claimed that cultural competency efforts will (1) lead to a greater understanding of Islam and Islamic culture, thereby improving the patient-provider relationship, and (2) improve Muslim experiences within the healthcare system, resulting in reduced challenges and increased accommodations.

Participants highlighted their experiences with healthcare providers who lacked knowledge about their faith and cultural practices. There was an expectation that providers should have a basic level of knowledge about their patients. As one frustrated participant remarked, "A lot of doctors ask really basic things and you're kind of like...they should already (know) that stuff." One participant wished that healthcare providers would have a basic understanding of American Muslims in order to decrease the burden of having to explain their culture and religious beliefs and practices, "That every one of us has to sit, educating her doctor about her beliefs. It's general information - he can take a two-hour presentation. He can learn this, and that's it. And then you don't - each particular patient has to sit and educate." Another participant suggested, "It would be good for hospitals to do some, at the hospital they teach other people about our religion and our culture. Because sometimes, people act the way they do out of ignorance. They don't know...the beliefs and the way Muslims behave." Additionally, participants asserted that Muslims are often stereotyped and generalized, despite the community's diversity. As one person remarked, "I think also we get stereotyped or maybe they have a few in-services at the hospital and everyone thinks they know everything about Muslims when we're all very, very different, so ask." Consequently, participants said that cultural competency efforts should educate healthcare practitioners about basic Islamic beliefs and practices, thus helping to reduce stereotypical care and discrimination.

Participants often described the healthcare system's atmosphere as unwelcoming, one in which "doctors and nurses...everybody...looks at you like (a) stranger or like you will be a problem for them." One participant shared, "I think we all know of stories where due to someone having an accent or...appearing Muslim...that sometimes the doctors may be more blunt with you, or they...belittle you, or not...give you the time of day." Participants also said that Muslim patients run the risk of being treated negatively when requesting accommodations for their religious and cultural beliefs. One participant related her experience with a male doctor who became upset after she requested a female OB/GYN. At times, providers may not take such requests seriously, "think(ing) it's a big joke..."

Participants also said that Muslim patients run the risk of being treated negatively when requesting accommodations for their religious and cultural beliefs.

³⁷ Anderson LM, Scrimshaw SC, Fullilove MT, Fielding JE, Norman J. Culturally competent healthcare systems. *American Journal of Preventive Medicine*. 2003;24(3S):68-79.

or a bunch of old-fashioned foolishness they don't want to be bothered with." Participants clarified that if healthcare practitioners understood why these accommodations were requested, they would be more likely to treat Muslim patients with respect and create a more welcoming atmosphere. Given that negative health care experiences can impact healthcare-seeking patterns, making an effort to accommodate Muslim patients can lead to greater provider-patient trust, which will ultimately impact healthcare-seeking patterns and compliance with the suggested treatments:

When the nurse...tells you...I respect your religion...immediately, I will have trusted her...That's half of the work of being a healthcare giver...to get the trust of the patient. When the patient trusts you, he will do anything you tell him...and he will be compliant with care. So if you take the extra mile, this is (a) very important issue (for) healthcare providers. They have to make the effort to respect and to assess.

Finally, our participants noted that these accommodations could be provided rather easily and required some flexibility and strategic planning, *"Why don't we go the extra mile with...Muslims? ...Their needs are very tiny... What's the big deal..."* In addition, the results of doing so will lead to improved healthcare experiences for both parties. These patient perspectives suggest the need for health systems to utilize cultural competency initiatives and train staff in order to improve interpersonal interactions, thereby enhancing cultural sensitivity and contributing to positive changes in the overall health system culture.

PRIORITY HEALTHCARE ACCOMODATIONS

Given the different conceptions of health and healing, cultural modifications and healthcare accommodations may be integral to providing the highest quality of care. Prior research demonstrates that many hospitalized Muslim patients seek to maintain their religious practices: fasting during Ramadan, adhering to dietary restrictions, and observing the prescribed and optional prayers are just some examples. Within the framework of cultural competence, our focus group participants identified three healthcare accommodations as top priorities: (1) Gender-concordant care (2) Halal food, and (3) Prayer space.

Gender-Concordant Care

Participants requested gender-concordant care based upon Islamic conceptions of modesty and privacy.³⁸ Some of them further described how the lack of female personnel may play a role in delaying or avoiding healthcare services, *"Yeah. I would not even walk into a clinic that I didn't have a choice of the gender."* Gender-concordant care was also discussed in relation to helping patients maintain a secure and private space, such as a hospital room, as well as protecting the body's personal space. In the event that such care was unavailable, participants made some further recommendations, such as more modest hospitals gowns and signs on the doors that requested providers to knock and wait for permission to enter.

³⁸Padela AI, del Pozo PR. Muslim patients and cross-gender interactions in medicine: an Islamic bioethical perspective. *Journal of medical ethics*. 2011;37(1):40.

Halal Food

The provision of halal (Islamically slaughtered) food was also identified as an important healthcare accommodation. Some patients requested it for health reasons, and many identified food in general as a priority area in which healthcare providers could take the initiative. One participant stated, *"I would also think that (the) hospital needs to take the initiative to ask every patient, do you have any dietary restrictions or even preferences. Because some people again, not being a very good advocate for themselves aren't going to ask and they're just going to assume...that they get what they get."* This quote speaks to a common theme in our focus groups: patients feel that they are outsiders and thus experience a further degree of stigmatization when asking for or explaining their need for certain accommodations.

Prayer Space

Participants identified prayer space as an important healthcare accommodation due to prayer's role in healing and as a ritual five-time daily obligation. Participants described the challenges they had faced and suggested that a religiously neutral space would be welcomed. Some hospitalized participants mentioned being interrupted while praying and experiencing discomfort. One participant told of her effort to find a suitable place, *"I had knee surgery so couldn't go anywhere, and I was very worried about that...my husband was with me and put me in a wheelchair and wheeled me to the bathroom, I (supplcated) and I came back and prayed."* Another participant described an uncomfortable experience, *"So we were praying but...nurses and...security had come and asked if everything was ok...Doctors were you know, hesitant to come back in the room and...everybody came by after that and kind of looked in the door...we just praying how we pray."*

As previously mentioned, understanding American Muslim perspectives on health and healing requires that the role of religion, cultural beliefs, values, and worldviews of Islam be understood as well. Once this happens, hospital-based barriers to quality care can be identified. Providing culturally appropriate healthcare accommodations is integral to the care of American Muslim patients, and allocating resources that can serve as a source of comfort and fulfill these patients' spiritual needs can help fulfill that goal.

THE ROLE OF IMAMS

A logical starting point for recognizing Islam's influence upon its adherents' health may be to understand the roles an imam is expected to assume. For the purpose of this report and within the American context, we define an imam as the man who leads the prayers, gives the sermon, and advises the congregation on spiritual matters. His community-based role is analogous to that of a priest, a minister, or a rabbi (Table 3). While medical literature is replete with studies describing rabbi-priest partnerships to improve their community members' health, respectively, and while chaplaincy programs have effectively incorporated them within the hospital system, few imams have been included in such initiatives. Therefore, further research is needed to delineate their multiple

roles in American Muslim health.³⁹⁻⁴¹ Surprisingly, few studies have examined the imam's importance in the Muslims' medical decision-making processes.⁴²⁻⁴⁴ Non-Muslim chaplains, however, have recognized that imams should be available to minister to Muslim patients.⁴⁵

The scant international literature suggests that imams and mosque-based interventions can enhance community health and reduce healthcare disparities. For example, educating imams about tuberculosis resulted in sermons on the topic and increased detection and treatment in Bangladesh.⁴⁶ Mosque-based lecture series on cardiovascular disease risk factors have helped advance health in Austria.⁴⁷ A similar approach has recently been adopted by USAID's Bureau for Global Health: imams are mobilized to be "champions" of reproductive health and family planning in multiple Muslim-majority nations.⁴⁸ Imams also serve as religious "translators" and cultural brokers while visiting hospitalized Muslims, provide ethical consultation for both staff and patients, and are involved in patient-provider-family healthcare discussions.⁴⁹

Imams also play key roles in their community's health, as they are perceived as counselors and a source of spiritual cures.^{50,51} Our participants identified four central healthcare-related roles for imams: (1) encouraging healthy behavior through scripture-based messages in sermons; (2) performing religious rituals around life events and illnesses; (3) advocating for Muslim patients and delivering cultural sensitivity training in hospitals; and (4) helping Muslims make healthcare decisions.

39 Campbell MK, Hudson MA, Resnicow K, Blakeney N, Paxton A, Baskin M. Church-Based Health Promotion Interventions: Evidence and Lessons Learned. *Annual Review of Public Health*. 2007;28(1):213-234.

40 Flannelly KJ, Weaver AJ, Smith WJ, Oppenheimer JE. A systematic review on chaplains and community-based clergy in three palliative care journals: 1990-1999. *American Journal of Hospice and Palliative Medicine*. July 1, 2003 2003;20(4):263-268.

41 Shuper A, Zeharia A, Balter-Seri J, Steier D, Mimouni M. The paediatrician and the rabbi. *Journal of medical ethics*. 2000;26(6):441-443.

42 Kendall-Raynor P. Cultural understanding. *Nursing Standard*. 2007;22(4):22-23.

43 Ali OM, Milstein G, Marzuk PM. The Imam's Role in Meeting the Counseling Needs of Muslim Communities in the United States. *Psychiatr Serv*. February 1, 2005;56(2):202-205.

44 Ahmad NM. Arab-American culture and health care. *Public Health Management & Policy* 2004: <http://www.cwru.edu/med/epidbio/mphp439/Arab-Americans.htm>.

45 Abu-Ras W. Chaplaincy Services for Muslim Patients in New York City Hospitals: Assessing Needs, Barriers, and the Role of Muslim Chaplains: Institute for Social Policy and Understanding; 2010.

46 Rifat M, Rusen ID, Mahmud MH, Nayer I, Islam A, Ahmed F. From Mosques to Classrooms: Mobilizing the Community to Enhance Case Detection of Tuberculosis. *Am J Public Health*. September 1, 2008 2008;98(9):1550-1552.

47 Bader A, Musshauer D, Sahin F, Bezirkan H, Hochleitner M. The Mosque Campaign: a cardiovascular prevention program for female Turkish immigrants. *Wiener Klinische Wochenschrift*. 2006;118(7):217-223.

48 Freij LS. ES Model: Mobilizing Muslim Imams and religious leaders as "Champions" of reproductive health and family planning. In: Project TESD, ed. 2010.

49 DeVries R, Berlinger N, Cadge W. Lost in Translation: The Chaplain's Role in Health Care. *Hastings Center Report*. 2008;38(6):23-27.

50 Abu-Ras W, Gheith A, Cournois F. The Imam's Role in Mental Health Promotion: A Study of 22 Mosques in New York City's Muslim Community. *Journal of Muslim Mental Health*. 2008;3:155-176.

51 Padela A, Killawi A, Heisler M, Demmoner S, Fetters M. The Role of Imams in American Muslim Health: Perspectives of Muslim Community Leaders in Southeast Michigan. *Journal of Religion and Health*. 2010:1-15.

Table 3: A Brief Taxonomy of Imams

Type	Description	Comment
Imam = Prayer-leader	The most general definition of an imam is a congregational prayer leader.	This individual leads prayers at a mosque at specific times formally or informally. The term can also be used for an individual who leads prayer once for a group of people and may not do so on a regular basis.
Sermon-Giver = Imam and/or Khateeb	Gives sermons that are a requisite part of Friday (Jummah) prayer services and Holiday services (Eid).	This individual often, but not always, has some level of Islamic educational attainment and is asked to give sermons by the mosque leadership.
Spiritual Guide = Imam and/or Shaykh	Sought out by Muslims for spiritual guidance around life events, the esoteric sciences related to purifying one's character and belief, and "spiritual cures."	This individual is often referred to as a Shaykh which is also a ubiquitous term in the Islamic tradition. Such an individual is often associated with Sufi paths in the Islamic tradition.
Islamic Law Expert = Imam and/or Shaykh	Studied Islamic law and ethics extensively through formalized Islamic seminaries and colleges. Specialized in Islamic law and is authorized to issue religious edicts (sing. Fatwa, pl. fatawa).	The legal theorists of the classical era who promulgated the dominant extant schools of Islamic law (Maliki, Hanafi, Shafi, Hanbali, and Jafari) are all accorded the honorific title imam.
Director of Mosque = Imam and/or Shaykh	A mosque-based imam who is hired by the mosque administration to serve multiple roles for congregants, including religious ceremonies and prayers.	This individual may fulfill some or all of the types of imams listed above.

Participants discussed how imams may deliver health-based messages through sermons and lectures, especially during the congregational Friday prayer (*jum'uah*). Held at all mosques, *jum'uah* is obligatory upon all Muslim men and is often a family activity. In areas with large Muslim populations, multiple prayer sessions and sermons may be conducted at a single mosque, lending variety to both the message

and the messenger. Participants related that by framing disease and healing as coming from God, imams help Muslims cope with illness by helping them maintain hope in the Divine. Participants also alluded to imams' messages about moderation and health promotion, for example, *"to take care of our health...that (the body)...is a trust (from God)"* and to be moderate in eating, for the Qur'an states: *"Eat and drink and don't go beyond the limit"* (7:31). Participants remarked that imams sometimes use healthcare messages from the Qur'an to guide the audience's health and that some congregants expect to receive (and may desire more) health-focused sermons.

Participants also provided insight into how imams perform religious rituals connected with important life events and illnesses: blessing births, visiting the sick, overseeing funeral services, and many others. When asked about these responsibilities, one imam related, *"(Being an) imam entails...first and foremost, guiding the community...and also visiting a sick person...if somebody dies...either you get involved in the washing of the body or directing...people how to do that and...praying for the deceased person."* Thus, imams serve important ritualistic functions associated with life and death. In fact, hospitalized Muslims may even request their presence. In addition to these functions, participants noted that imams are often requested to make special prayers for sick congregants and/or their relatives. Participants shared that some Muslims believe that reciting certain Qur'anic verses and certain prayers over food can have healing qualities, and thus they may request imams to do so. Some imams may serve a more direct therapeutic role as counselors and alternative mental healthcare providers.

Participants illustrated how imams can take on larger roles within the hospital and healthcare system as part of their religious duty to visit the sick. One healthcare worker said, *"Maybe a sheikh (imam) comes from the masjid (mosque) (to educate healthcare workers about) when you come across these Muslims, this is the kind of belief...that you might encounter."* The goal here is to provide staff with a cultural knowledge base and tools that can help healthcare professionals understand and facilitate care that is attuned to Muslim beliefs. As one of our imams noted, *"Many of the staff...have no idea what Muslims believe...once they know that, they are more sensitive and they know how to approach (Muslims)...and how to respect them and not offend them."* Our respondents noted that few imams have formal hospital appointments, and thus *"many patients are surprised when they know that (t) here is (an) imam on...staff to visit them, and to take care of them, and make sure that their traditional beliefs are respected."* This illustrates how imams can serve as cultural brokers.

Respondents also provided examples of how imams play an integral role in healthcare decision-making for Muslims within hospital and mosque settings. For example, one participant observed how they function at his hospital in family meetings: *"[W]e have (had) to invite local imams to sit in on family meetings with physicians to help the family make the decision with, as far as considering the faith and the rulings because...they just had the medical advice so...(the family) wanted religious advice."* One

imam explained that imams seek to “*try to close the gap between physicians and family*” and “*inform them (the healthcare staff and patient family) what can be done and what cannot be done according to religion.*” This reveals how imams can function as interpreters and cultural brokers. Healthcare partnerships with imams and their mosques may be an important way to enhance this community’s health. Moreover, some participants described how imams may facilitate cultural competency efforts for the healthcare system. Our project also identified the need for further research related to the challenges of involving imams in healthcare settings.

CHALLENGES IN PROVIDING CULTURALLY SENSITIVE HEALTHCARE

Many factors pose challenges to providing culturally sensitive healthcare and accommodations to American Muslim patients. These challenges are discussed in this section, with a particular focus on patient-provider interactions, the limitations of non-Muslim chaplains in healthcare settings, and the benefits and limitations of imams in healthcare settings.

American Muslim patients who have to deal with physicians who will neither accommodate their religious and cultural traditions nor fulfill their duty to communicate with and educate them may rely more heavily on folk medicine and spiritual cures in lieu of allopathic treatment. This pattern has been suggested in other studies of the American Muslim community and is not unique to it.⁵²⁻⁵⁵ Patient-provider communication difficulties, mistrust, and perceived discrimination all play a part in minority healthcare disparities and contribute to a poorer quality of healthcare in general.⁵⁶⁻⁵⁸ Furthermore, poor patient-provider dynamics influence patients’ decisions not to consume allopathic medicine and to conceal their use of alternative medicines. Such a situation contributes to delaying healthcare efforts.^{59,60}

Given that allopathic providers are only one source of healing for American Muslims, a strong patient-doctor alliance is important. Some of our participants expressed concern that physicians sometimes did not accommodate their religious and cultural needs and exhibited distant communication styles. For example, some providers may see ritual fasting as harmful to the body or the rejection of porcine-based products as zealotry. Yet our participants affirmed how these practices can be essential to maintaining their faith

52 Chao MT, Wade C, Kronenberg F, Kalmuss D, Cushman LF. Women’s reasons for complementary and alternative medicine use: racial/ethnic differences. *Journal of Alternative & Complementary Medicine*. Oct 2006;12(8):719-720.

53 Kronenberg F, Cushman LF, Wade CM, Kalmuss D, Chao MT. Race/ethnicity and women’s use of complementary and alternative medicine in the United States: results of a national survey. *Am J Public Health*. Jul 2006;96(7):1236-1242.

54 Barnes PM, Powell-Griner E, McFann K, Nahin RL. Complementary and alternative medicine use among adults: United States, 2002. *Advance Data*. May 27 2004;(343):1-19.

55 Astin JA. Why patients use alternative medicine: results of a national study. *JAMA*. May 20 1998;279(19):1548-1553.

56 Saha S, Freeman M, Toure J, Tappin KM, Weeks C, Ibrahim S. Racial and ethnic disparities in the VA health care system: a systematic review. *J Gen Intern Med*. May 2008;23(5):654-671.

57 Williams DR, Mohammed SA. Discrimination and racial disparities in health: evidence and needed research. *J Behav Med*. Feb 2009;32(1):20-47.

58 Williams RA. *Eliminating healthcare disparities in America: beyond the IOM report*. Totowa, N.J.: Humana Press; 2007.

59 Lee YY, Lin JL. Linking patients’ trust in physicians to health outcomes. *Br J Hosp Med (Lond)*. Jan 2008;69(1):42-46.

60 Chao MT, Wade C, Kronenberg F. Disclosure of complementary and alternative medicine to conventional medical providers: variation by race/ethnicity and type of CAM. *J Natl Med Assoc*. Nov 2008;100(11):1341-1349.

identity and are of primary importance to them. Such misunderstandings have important implications for healthcare utilization, given that a variety of healing patterns emerged within our focus groups. Some participants held religious cures to be primary and so used allopathic medicines as secondary sources of healing, while others used them as integrative choices. Further work is needed to explore the linkages between the quality of patient-doctor relationships and community members' utilization patterns for alternative and spiritual therapies. Our findings suggest that there is a continuing need for healthcare providers to improve their cross-cultural communication skills and enhance their level of cultural sensitivity.

The importance of religion and spirituality in supporting individuals and families within hospital settings is often facilitated by professional chaplaincy organizations.⁶¹⁻⁶³ From the healthcare system perspective, chaplains provide spiritual support to patients. While these chaplaincy and pastoral care programs have largely emerged from the Judeo-Christian healing traditions, efforts to incorporate other faith traditions are underway. Little attention has been paid to the role of Muslim chaplains within healthcare settings.⁶⁴ Pastoral care and chaplaincy training programs rarely include education on Islam, and it is not clear if non-Muslim chaplains feel morally comfortable counseling Muslims.^{65,66} For example, a study of directors and chaplains associated with New York City pastoral care departments revealed that non-Muslim chaplains had a limited awareness and understanding of the needs of Muslim patients.⁶⁷ Thus, hospital chaplains may not be able to meet them. On the other hand, hospitals may lack the financial resources or perceive Muslim patient volumes as insufficient to justify hiring a Muslim chaplain. A further barrier may be that hospitals often require chaplaincy credentials, and there are only a few Islamic chaplaincy programs in the United States.⁶⁸⁻⁷⁰

As noted earlier, imams and chaplains have similar functions, such as providing spiritual support and religious advice for Muslim patients and their families. Research within the United States notes the beneficial role imams can play in promoting mental health through counseling and healthcare initiatives. Our research also

61 Chaplains AoP, Education AfCP, Education CAfPPa, Chaplains NAOc, Chaplains NAOJ. A White Paper. Professional chaplaincy: Its role and importance in healthcare. *Journal of Pastoral Care*. Spring 2001;55(1):81-97.

62 Ford T, Tartaglia A. The development, status, and future of healthcare chaplaincy. *The Southern Medical Journal*. 2006;99(6):675-679.

63 VandeCreek L, Burton L. Professional chaplaincy: Its role and importance in healthcare. *The Journal of Pastoral Care*. 2001;55(1):81-97.

64 Abu-Ras W. Chaplaincy Services for Muslim Patients in New York City Hospitals: Assessing Needs, Barriers, and the Role of Muslim Chaplains: Institute for Social Policy and Understanding; 2010.

65 Hamza DR. Faith-Based Practice On Models of Hospital Chaplaincies: Which One Works best for the Muslim Community? *Journal of Muslim Mental Health*. 2007;2:65-79.

66 Abu-Ras W, Laird L. How Muslim and non-Muslim chaplains serve Muslim patients. Does the interfaith chaplaincy model have room for Muslims' experiences? *Journal of religion and health*. 2010;50(1):46-61.

67 Abu-Ras W. Chaplaincy Services for Muslim Patients in New York City Hospitals: Assessing Needs, Barriers, and the Role of Muslim Chaplains: Institute for Social Policy and Understanding; 2010.

68 The Fairfax Institute. 2006; <http://www.fairfaxi.net/163034.html>. Accessed January 19, 2010.

69 Dudhwala IY. The Growth of Muslim Chaplaincy in the UK. 2008; <http://www.plainviews.org/AR/c/v5n13/a.html>. Accessed January 19, 2010;

70 Islamic Chaplaincy Program. <http://macdonald.hartsem.edu/chaplaincy/index.html>. Accessed January 19, 2010.

suggests several tangible benefits with respect to American Muslim health behaviors.⁷¹⁻⁷⁴ In our experience and that of other researchers, even in areas with large Muslim populations, few imams have formal chaplaincy roles in the hospital.⁷⁵ This might be due to a lack of time given their mosque-based responsibilities, feeling uncomfortable about assuming such a role due to their limited medical knowledge, and viewing chaplaincy as alien to their understanding of supporting the sick as a communal, not an individual, obligation.^{76, 77}

The imams in our sample felt uneasy about making medical decisions for patients, due to the uncertainties of medical science, and expressed discomfort with being asked to convince them to pursue physician recommendations through religion-based argumentation. Some of these ethical conflicts may also stem from imams' lack of familiarity with the healthcare system and medicine in general. The barriers and potential limitations to their involvement in the healthcare system must be delineated more thoroughly, and the types of ethical challenges they face have to be explored as well. Ensuring culturally sensitive care is a multi-faceted challenge and merits a consideration of American Muslim patient beliefs and preferences regarding healthcare accommodations and spiritual support in the hospital. For example, a clearer definition of the core competencies required to become a Muslim chaplain and an increased focus on the spiritual needs of minority religious groups in chaplaincy programs may help address such concerns. Finally, it is critical to consider how these challenges manifest themselves at the individual level, within the patient-provider relationship, and in response to the system-level constraints that limit spiritual support for hospitalized Muslims.

RECOMMENDATIONS

Several changes in policies and healthcare delivery may provide tangible solutions to the above-mentioned concerns. Based on our project's findings, we recommend the following:

- Healthcare providers can better situate medical interventions within an American Muslim cultural framework by increasing their understanding of how American Muslims view health and healing. Assessing

71 Ali OM, Milstein G, Marzuk PM. The Imam's Role in Meeting the Counseling Needs of Muslim Communities in the United States. *Psychiatr Serv*. February 1, 2005;56(2):202-205.

72 Padela A, Killawi A, Heisler M, Demonner S, Fetters M. The Role of Imams in American Muslim Health: Perspectives of Muslim Community Leaders in Southeast Michigan. *Journal of Religion and Health*. 2010;1-15.

73 Abu-Ras W, Gheith A, Cournos F. The Imam's role in mental health promotion: A study of 22 Mosques in New York city's Muslim community. *Journal of Muslim Mental Health*. 2008;3:155-176.

74 Taylor JY, Holtrop TG. Yemeni families and child lead screening in Detroit. *Journal of Transcultural Nursing*. 2007;18(1):63-69.

75 Abu-Ras W, Laird L. How Muslim and non-Muslim chaplains serve Muslim patients. Does the interfaith chaplaincy model have room for Muslims' experiences? *Journal of religion and health*. 2010;50(1):46-61.

76 Abu-Ras W, Laird L. How Muslim and non-Muslim chaplains serve Muslim patients. Does the interfaith chaplaincy model have room for Muslims' experiences? *Journal of religion and health*. 2010;50(1):46-61.

77 Dudhwala IY. Building bridges between theology and pastoral care <http://www.eurochaplains.org>. Accessed January 19, 2010.

and understanding their views on healing will enable healthcare providers to establish trust, enhance patient-provider relationships, avoid issues of non-disclosure, and reduce patient non-adherence to recommended therapies. Providers may also consider engaging structures and agents outside of the allopathic system who can better meet patient needs and enhance health.

- All patients, regardless of their religious beliefs or practices, want to receive care in a welcoming environment. Hence, health systems should train staff to enhance cultural sensitivity, reduce discrimination, and highlight intra-group differences.
- Health systems should ask patients if they prefer same-gender providers and make good-faith efforts to do so when requested. Our data suggests that this accommodation, above all others, can influence healthcare-seeking patterns. Further delineation of the import, significance, impact, and extent to which this accommodation is necessary is warranted. Our participants suggested that efforts to accommodate and respect patient privacy and modesty can be addressed in several ways:
 - o Knocking and waiting for permission to enter, so that patients can dress appropriately. For example, some Muslim women may want to don the headscarf.
 - o Providing hospital gowns and clothing that accommodate patient preferences for modesty and privacy.
 - o Placing, at the patient's request, or offering the option of a sign designating the room as a same-gender provider only.
 - o Informing a patient in advance that a person of the other gender may need to enter the room.
- Hospitals should provide halal foods and medications to alleviate the stress and discomfort caused by being confronted with substances that violate their religious beliefs.
- Health systems should consider allocating space for Muslims to pray. As some patients may pray in their hospital rooms, staff should be made aware of this practice and told not to disturb praying patients.
- Healthcare institutions should reach out to American Muslims by initiating religiously and culturally sensitive healthcare awareness campaigns through partnerships with mosques. This will allow healthcare systems and imams to explore how sermons and educational venues may be used to disseminate health messages regarding disease prevention.

- Health systems should consider implementing educational programs in healthcare settings so that hospital pastoral care and chaplaincy staff, as well as healthcare providers, can become more aware of the spiritual needs of American Muslim patients. Imams and Muslim healthcare providers may serve as potential resources and sources of support for patients.

LIMITATIONS

The examples and recommendations cited within this report underscore the need for increased cultural competence on the part of health systems and healthcare staff, as well as the need to address cultural and religious accommodations within the healthcare system. Given that we sought to uncover how Islam influences health and healthcare decisions, we looked for participants among those who regularly attended their local mosque on the grounds that they provided a first-cut for identification with Islam and for personal religiosity. While our data legitimately represent the voices of a key community segment, the participants do not represent a full cross-section of the community in that those who did not go to the mosque were not sampled. Given that our participants were from a large and well-established community, we believe that their views offer invaluable insight into the American Muslim community at large. We also note that other communities may hold different priorities and views.

Conclusion

The paucity of research and published data on the healthcare needs of American Muslim patients suggests that ongoing research into the above-mentioned barriers to optimal health and healthcare delivery is necessary. Studying American Muslim health is quite a challenge, for the lack of accurate population statistics and capturing of religious affiliation within national databases affects sampling frames and research designs. The quantification of mechanistic relations between Islam, health practices and behaviors, and population health requires a concerted, systematic, and sustained engagement on multiple levels involving community, state, and national actors. This report highlights several areas of research that may inform and augment healthcare services to American Muslims. For example, their healthcare-seeking patterns may be influenced by the provision or absence of cultural accommodation in healthcare settings that, in turn, may cause them to delay seeking care or to adopt alternative healing practices. Understanding the relationships between Islamic beliefs and practices and how they affect clinical encounters provides an opportunity to improve community health and deliver culturally sensitive, high quality care.

The qualitative literature captures some of Islam's influences upon American Muslim health values and behaviors; however, these studies often focus on only one ethnic group.⁷⁸ Hence, the strength of our work lies in its incorporation of African Americans, South Asian Americans, and Arab Americans, as well as Sunni and Shi'ite groups. We advocate for additional studies that give voice to patient perspectives on health and healing and highlight their experiences in healthcare settings.

An additional challenge is how to inform healthcare providers of this community's perspectives on health and illness while explaining its heterogeneity. Developing and validating Islam-based measures of religiosity, which are integral to exploring associations between religion and health behaviors, remain in the preliminary stage.⁷⁹ Thus, future research should include studies that capture perspectives and experiences from multiple Muslim communities, as well as from Muslims with varying levels of religious adherence, and should reflect the diversity of their members' socioeconomic status and level of acculturation. Our work represents a critical first step in setting such research agendas. Further studies in collaboration with American Muslim communities across the country are required to address current gaps in our knowledge about how they utilize healthcare services and the challenges they face in healthcare settings, while also exploring potential resources, policies, and practices that can enhance cultural competence and accommodation.

78 Beine K, Fullerton J, Palinkas L, Anders B. Conceptions of prenatal care among Somali women in San Diego. *Journal of Nurse-Midwifery*. Jul-Aug 1995;40(4):376-381.

79 Amer MM, Jr. RWH. Special Issue: Part II. Islamic Religiosity: Measures and Mental Health. *Journal of Muslim Mental Health*. 2008;3(1):1-5.

Institute *for* Social Policy *and* Understanding

ISPU is an independent, nonpartisan think tank and research organization committed to conducting objective, empirical research and offering expert policy analysis on some of the most pressing issues facing our nation, with an emphasis on those issues related to Muslims in the United States and around the world. Our research aims to increase understanding of American Muslims while tackling the policy issues facing all Americans, and serves as a valuable source of information for various audiences. ISPU scholars, representing numerous disciplines, offer context-specific analysis and recommendations through our publications. The diverse views and opinions of ISPU scholars expressed herein do not necessarily state or reflect the views of ISPU, its staff, or trustees.



Institute *for* Social Policy *and* Understanding

1225 Eye Street, Nw, Suite 307, Washington, DC, 20005 | 1.800.920.ISPU (4778) | info@ispu.org

www.ispu.org

ATTACHMENT B

Pages Amending the Original CON Permit Application

"ORIGINAL – AMENDED"ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION****This Section must be completed for all projects.****Facility/Project Identification**

Facility Name: Preferred SurgiCenter		
Street Address: 10 Orland Square Drive		
City and Zip Code: Orland Park, Illinois 60462		
County: Cook	Health Service Area: 7	Health Planning Area: A-04

Applicant /Co-Applicant Identification**[Provide for each co-applicant [refer to Part 1130.220].**

Exact Legal Name: Preferred SurgiCenter, LLC
Address: 10 Orland Square Drive, Orland Park, Illinois 60462
Name of Registered Agent: Naser Rustom, M.D.
Name of Chief Executive Officer: Naser Rustom, M.D. (Sole Member)
CEO Address: 10 Orland Square Drive, Orland Park, Illinois 60462
Telephone Number: (708) 942-6000

Type of Ownership of Applicant/Co-Applicant

<input type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental
<input checked="" type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship
	<input type="checkbox"/> Other

Corporations and limited liability companies must provide an **Illinois certificate of good standing**.
 Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT-1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact

[Person to receive all correspondence or inquiries during the review period]

Name: Robyn Fina
Title: Manager
Company Name: Preferred SurgiCenter, LLC
Address: 10 Orland Square Drive, Orland Park, Illinois 60462
Telephone Number: (708) 942-6000
E-mail Address: mrsillinois2000@aol.com
Fax Number: (708) 942-6001

Additional Contact

[Person who is also authorized to discuss the application for permit]

Name: Joseph Hylak-Reinholtz
Title: Attorney
Company Name: Holland & Knight LLP
Address: 131 South Dearborn Street, Floor 30, Chicago, Illinois 60603
Telephone Number: (312) 715-5885
E-mail Address: JHReinholtz@hklaw.com
Fax Number: (312) 578-6666

Additional Contact

[Person who is also authorized to discuss the application for permit]

Name: Jeffrey Mark
Title: Consultant
Company Name: JSMA Healthcare
Address: 1182 S. Plymouth Court, 1SW, Chicago, Illinois 60605
Telephone Number: (312) 804-9401
E-mail Address: jmark@jsma.com
Fax Number: (312) 578-6666

2. Narrative Description

Provide in the space below, a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does **NOT** have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

Preferred SurgiCenter, LLC ("Applicant") proposes to establish a multi-specialty ambulatory surgical treatment center ("ASTC") with four (4) "treatment rooms." The treatment rooms will include three (3) operating rooms and one (1) procedure room ("Project"). The ASTC will be located at 10 Orland Square Drive, Orland Park, Illinois 60462. The Project's site is located within Health Service Area 7.

The proposed ASTC will consist of 6,800 departmental gross square feet ("DGSF") of clinical space and 2,000 DGSF of non-clinical space, for a total of 8,800 DGSF of space.

The Project will be located within an existing structure and will require the modernization of existing space (i.e., no new construction will be required for the Project).

The categories of surgical specialties that will be provided at the proposed ASTC will include the following: (i) gastroenterology, (ii) general surgery, (iii) pain management, (iv) orthopedics, (v) obstetrics/gynecology, and (vi) podiatry. None of the physicians making referrals to the proposed ASTC will hold an ownership interest in the ASTC.

The Project involves the establishment of a new health care facility; therefore, this is a Substantive project. The proposed ASTC is a Category B project because the Project's total cost is greater than \$2 million.

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must equal.

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs	\$20,000	\$10,000	\$30,000
Site Survey and Soil Investigation	\$0	\$0	\$0
Site Preparation	\$50,000	\$15,000	\$65,000
Off Site Work	\$0	\$0	\$0
New Construction Contracts	\$0	\$0	\$0
Modernization Contracts	\$1,450,000	\$250,000	\$1,700,000
Contingencies	\$80,000	\$20,000	\$100,000
Architectural/Engineering Fees	\$150,000	\$30,000	\$180,000
Consulting and Other Fees	\$15,000	\$5,000	\$20,000
Movable or Other Equipment (not in construction contracts)	\$925,000	\$75,000	\$1,000,000
Bond Issuance Expense (project related)	\$0	\$0	\$0
Net Interest Expense During Construction (project related)	\$0	\$0	\$0
Fair Market Value of Leased Space or Equipment	\$550,000	\$125,000	\$675,000
Other Costs To Be Capitalized	\$0	\$0	\$0
Acquisition of Building/Other Property (excluding land)	\$0	\$0	\$0
TOTAL USES OF FUNDS	\$3,190,000	\$580,000	\$3,770,000
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	\$3,190,000	\$580,000	\$3,770,000
Pledges	\$0	\$0	\$0
Gifts and Bequests	\$0	\$0	\$0
Bond Issues (project related)	\$0	\$0	\$0
Mortgages	\$0	\$0	\$0
Leases (fair market value)	\$0	\$0	\$0
Governmental Appropriations	\$0	\$0	\$0
Grants	\$0	\$0	\$0
Other Funds and Sources	\$0	\$0	\$0
TOTAL SOURCES OF FUNDS	\$3,190,000	\$580,000	\$3,770,000
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Purchase Price: \$	_____	
Fair Market Value: \$	_____	

The project involves the establishment of a new facility or a new category of service
 Yes No

If yes, provide the dollar amount of all **non-capitalized** operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.

Estimated start-up costs and operating deficit cost is \$100,000.

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:

None or not applicable Preliminary

Schematics Final Working

Anticipated project completion date (refer to Part 1130.140): January 1, 2016

Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):

Purchase orders, leases or contracts pertaining to the project have been executed.

Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies

Project obligation will occur after permit issuance.

APPEND DOCUMENTATION AS ATTACHMENT-8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals -- NONE OF THE FOLLOWING APPLY (APPLICANT IS A NEW ENTITY)

Are the following submittals up to date as applicable:

Cancer Registry

APORS

All formal document requests such as IDPH Questionnaires and Annual Bed Reports have been submitted

All reports regarding outstanding permits

Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

- o in the case of a corporation, any two of its officers or members of its Board of Directors;
- o in the case of a limited liability company, any two of its managers or members (or the sole manger or member when two or more managers or members do not exist);
- o in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of Preferred SurgiCenter, LLC *
 in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act.
 The undersigned certifies that he or she has the authority to execute and file this application for
 permit on behalf of the applicant entity. The undersigned further certifies that the data and
 information provided herein, and appended hereto, are complete and correct to the best of his or
 her knowledge and belief. The undersigned also certifies that the permit application fee required
 for this application is sent herewith or will be paid upon request.



 SIGNATURE

Naser Rustom, M.D.

PRINTED NAME

Sole Member of LLC

PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 10th day of July, 2013



Signature of Notary

Seal



SIGNATURE

PRINTED NAME

PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this ____ day of _____, 2013

Signature of Notary

Seal

*Insert EXACT legal name of the applicant

SECTION VII - SERVICE SPECIFIC REVIEW CRITERIA

This Section is applicable to all projects proposing establishment, expansion or modernization of categories of service that are subject to CON review, as provided in the Illinois Health Facilities Planning Act [20 ILCS 3960]. It is comprised of information requirements for each category of service, as well as charts for each service, indicating the review criteria that must be addressed for each action (establishment, expansion and modernization). After identifying the applicable review criteria for each category of service involved, read the criteria and provide the required information, AS APPLICABLE TO THE CRITERIA THAT MUST BE ADDRESSED:

H. Non-Hospital Based Ambulatory Surgery

This section is applicable to all projects proposing to establish or modernize a non-hospital based ambulatory surgical treatment center or to the addition of surgical specialties.

1. Criterion 1110.1540(a), Scope of Services Provided

Read the criterion and complete the following:

a. Indicate which of the following types of surgery are being proposed:

<input type="checkbox"/> Cardiovascular	<input checked="" type="checkbox"/> Obstetrics/Gynecology	<input checked="" type="checkbox"/> Pain Management
<input type="checkbox"/> Dermatology	<input type="checkbox"/> Ophthalmology	<input checked="" type="checkbox"/> Podiatry
<input checked="" type="checkbox"/> Gastroenterology	<input type="checkbox"/> Oral/Maxillofacial	<input type="checkbox"/> Thoracic
<input checked="" type="checkbox"/> General/Other	<input checked="" type="checkbox"/> Orthopedic	<input type="checkbox"/> Otolaryngology
<input type="checkbox"/> Neurology	<input type="checkbox"/> Plastic	<input type="checkbox"/> Urology

b. Indicate if the project will result in a limited or a multi-specialty ASTC.

2. Criterion 1110.1540(b), Target Population

Read the criterion and provide the following:

- On a map (8 ½" x 11"), outline the intended geographic services area (GSA).
- Indicate the population within the GSA and how this number was obtained.
- Provide the travel time in all directions from the proposed location to the GSA borders and indicate how this travel time was determined.

3. Criterion 1110.1540(c), Projected Patient Volume

Read the criterion and provide signed letters from physicians that contain the following:

- The number of referrals anticipated annually for each specialty.
- For the past 12 months, the name and address of health care facilities to which patients were referred, including the number of patients referred for each surgical specialty by facility.
- A statement that the projected patient volume will come from within the proposed GSA.
- A statement that the information in the referral letter is true and correct to the best of his or her belief.

The following Sections **DO NOT** need to be addressed by the applicants or co-applicants responsible for funding or guaranteeing the funding of the project if the applicant has a bond rating of A- or better from Fitch's or Standard and Poor's rating agencies, or A3 or better from Moody's (the rating shall be affirmed within the latest 18 month period prior to the submittal of the application):

- Section 1120.120 Availability of Funds – Review Criteria
- Section 1120.130 Financial Viability – Review Criteria
- Section 1120.140 Economic Feasibility – Review Criteria, subsection (a)

VIII. - 1120.120 - Availability of Funds

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable: **Indicate the dollar amount to be provided from the following sources:**

\$3,095,000 _____	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to:
	1)	the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and
	2)	interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
\$675,000 _____	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including:
<i>FMV of Lease</i>	1)	For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated;
	2)	For revenue bonds, proof of the feasibility of securing the specified amount and interest rate;
	3)	For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.;
	4)	For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment;
	5)	For any option to lease, a copy of the option, including all terms and conditions.
_____	e)	Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
_____	f)	Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
_____	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
\$3,770,000	TOTAL FUNDS AVAILABLE	

APPEND DOCUMENTATION AS ATTACHMENT-39, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ATTACHMENT 7

Project Costs and Sources of Funds

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs	\$20,000	\$10,000	\$30,000
Site Survey and Soil Investigation	\$0	\$0	\$0
Site Preparation	\$50,000	\$15,000	\$65,000
Off Site Work	\$0	\$0	\$0
New Construction Contracts	\$0	\$0	\$0
Modernization Contracts	\$1,450,000	\$250,000	\$1,700,000
Contingencies	\$80,000	\$20,000	\$100,000
Architectural/Engineering Fees	\$198,591	\$58,409	\$257,000
Consulting and Other Fees	\$15,000	\$5,000	\$20,000
Movable or Other Equipment (not in construction contracts)	\$925,000	\$75,000	\$1,000,000
Bond Issuance Expense (project related)	\$0	\$0	\$0
Net Interest Expense During Construction (project related)	\$0	\$0	\$0
Fair Market Value of Leased Space or Equipment	\$550,000	\$125,000	\$675,000
Other Costs To Be Capitalized	\$0	\$0	\$0
Acquisition of Building/Other Property (excluding land)	\$0	\$0	\$0
TOTAL USES OF FUNDS	\$3,190,000	\$580,000	\$3,770,000
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	\$3,190,000	\$580,000	\$3,770,000
Pledges	\$0	\$0	\$0
Gifts and Bequests	\$0	\$0	\$0
Bond Issues (project related)	\$0	\$0	\$0
Mortgages	\$0	\$0	\$0
Leases (fair market value)	\$0	\$0	\$0
Governmental Appropriations	\$0	\$0	\$0
Grants	\$0	\$0	\$0
Other Funds and Sources	\$0	\$0	\$0
TOTAL SOURCES OF FUNDS	\$3,190,000	\$580,000	\$3,770,000

ATTACHMENT 9

Cost Space Requirements

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That IS:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
Reviewable							
Non-Hospital Based ASTC	\$3,190,000				6,800 DGSF		
<i>Total Clinical</i>	\$3,190,000				6,800 DGSF		
Non Reviewable							
Administrative, Waiting Room(s), Reception Area, Medical Record Storage, Other Non-Clinical	\$580,000				2,000 DGSF		
<i>Total Nonclinical</i>	\$580,000				2,000 DGSF		
Total	\$3,770,000				8,800 DGSF		

ATTACHMENT 12

Criterion 1110.230 -- Purpose of the Project

1. The proposed ambulatory surgical treatment center (the "ASTC") will provide health services that improve the health care and well-being of the population that resides in the geographic area intended to be served by the proposed ASTC. Preferred SurgiCenter, LLC (the "Applicant"), and its sole owner Dr. Naser Rustom (the "Sole Owner"), seek State Board approval to establish a multi-specialty ASTC, which will allow the creation of a first-of-its-kind health care facility that provides culturally sensitive health care services to persons who are of Arabic descent including, but not limited to, Arab Americans who are practicing Muslims. Although the Sole Owner intends to serve such persons at the ASTC and to ensure that the site is sensitive to the special needs of Arab and Muslim Americans, such as providing health care staff who are able to speak Arabic, the Sole Owner will ensure that the surgery center provides health care services to persons of all faiths. Accordingly, the Sole Owner is developing the ASTC to appeal to persons of all faiths and cultural backgrounds.
2. The proposed ASTC will be located at 10 Orland Square Drive, Orland Park, Illinois 60462. This site is in Health Service Area 7 and Hospital Planning Area A-04. The Applicant proposes a geographic service area (the "GSA") that includes all areas falling within a forty-five (45) minute drive time radius surrounding the site. The borders of the proposed GSA can be defined using the following geographic reference points:

Due to certain municipalities close proximity to exits off of key interstate highways such as I-88, the northwest border of the GSA reaches out to include the villages of Lisle and Warrenville, IL

The border directly to the north of the project site extends into Cook County's near northwest suburbs, including the towns of Wood Dale, Bensenville, Franklin Park, River Grove and Elmwood Park, IL. Inclusion of these towns results from easy access to expressways.

The GSA's NE border begins at the Lake Michigan shoreline, extending west at the northern border of Chicago zip code 60614. The NE boundary extends west, making zip codes 60625, 60630, and 60634 the NE border.

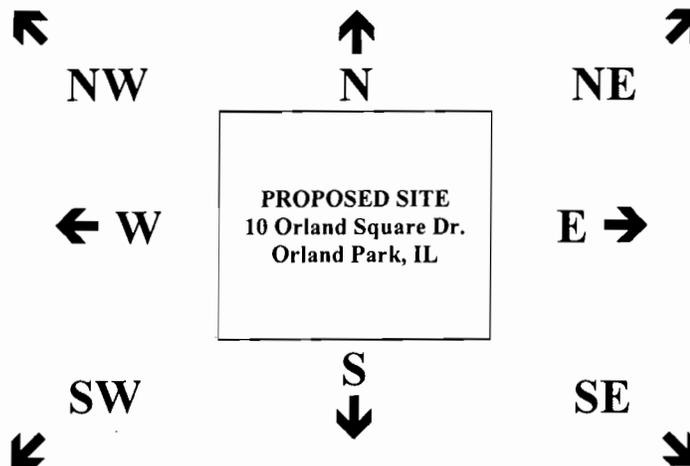
The border of the GSA directly to the west of the project site includes all of Plainfield, IL and reaches into the rural areas to the east of Oswego, IL

The border of the proposed GSA immediately east of the project site is the Illinois-Indiana border, extending generally from Lake Michigan down to the northern border of Crete, IL.

As the GSA's boundary heads to the east from Manteno, IL, it does not encompass Wilmington, IL, but does include Minooka and Channahon, IL.

At this point directly to the south of Orland Park, the GSA's boundary extends down Interstate 57 and includes the entire town of Manteno, IL and parts of Bourbonnais, IL.

Here, the GSA boundary extends away from the Illinois-Indiana border to the southwest, taking in parts of Beecher, IL and all of Peotone, IL.



A map of the proposed GSA showing its boundary is provided immediately following this Attachment 12.

3. The primary purpose of this project is to establish an ASTC that is able to meet the needs of all individuals residing within the GSA. The Applicant plans to establish an ASTC, which offers the highest quality of care, the latest technology, and the most advanced procedures from leading surgeons in their respective fields. *The Applicant intends to offer these high-quality services without regard to an individual patient's income level, ethnicity, cultural background, and/or religious faith. Furthermore, caring for the sick and the weak is a collective, societal responsibility according to the teachings of Islam.* As such, the Applicant will enroll in the Medicaid program and establish a charity care program, both of which will be explained further at Attachments 43 and 44. Accordingly, the Applicant's overriding goal with this project is to establish a multi-specialty ASTC *that appeals to the general population as a whole; but, to the trained eye, the ASTC will also be the first-ever surgery center that is designed and operated in a manner that meets the needs of Arab and Muslim Americans.*

The following discussion points are also main purposes of this project:

A. ASTCs are More Cost Effective Than Hospital Outpatient Departments.

It is well known that ASTCs are more cost effective than hospital outpatient departments ("HOPDs"). As a general rule, federal Medicare reimbursements to surgery centers are at a lower cost when compared with the equivalent procedure performed in an HOPD setting. The same is true under the Illinois Medicaid system, which reimburses ASTCs at a rate 75% of the equivalent hospital rate. The Applicant will be enrolling in the Medicare and Medicaid programs; and a number of cases currently performed at hospitals will be relocated to the new ASTC. This transfer of some elective operative cases from the hospital setting to a lower-cost ASTC setting should result in cost savings to the Medicare and Medicaid programs.

B. A New Multi-Specialty ASTC Will Not Harm Existing Providers; Project's Primary Goal is to Serve the Needs of Every Person in the GSA.

The proposed ASTC will not harm existing surgery centers and hospitals in the GSA that are the closest in proximity to the proposed ASTC's site because many of these providers are meeting or notably exceeding State Board standards. For example, the proposed GSA encompasses a geographic area that includes 50 existing surgery centers. However, of these 50, only 16 are within a 30 minute drive time radius from the proposed site, with the remaining 34 being within the City of Chicago or in the near west and northwest suburbs.

Of the closest ASTCs (i.e., those sites within a 30 minute drive time radius of Orland Park, Illinois), three have been recently approved and do not have utilization data on file with the State Board. Of the 13 remaining existing surgery centers, five have operating rooms ("ORs") that are fully utilized (i.e., each OR meets or exceeds 100% of the 1,500 hours of surgical time/OR state board standard) and another three are operating near or beyond 70% utilization. Two ASTCs with the greatest under-utilization are single specialty ASTCs that do not offer any of the surgical specialties being proposed in this CON permit application.

Similar performance is seen among the hospitals that fall within the proposed GSA. In regards to the hospitals in closest proximity to the proposed ASTC (i.e., those within a 30 minute drive time radius), well over half of the existing hospitals are either fully utilizing their ORs or are experiencing utilization rates ranging from 70% to 80%. In fact, four of the 13 hospitals are at or

ATTACHMENT 12

Criterion 1110.230 -- Purpose of the Project

exceed 100% capacity, while another four hospitals have utilization rates between 70% and 80%. While it is true that some of the existing hospital-based ORs are notably under-utilized, it is likely that factors outside of the State Board's control are influencing patient choice and their individual physician's willingness to use these facilities. In addition, many hospital ORs are held open for trauma cases or certain types of procedures, which lowers OR utilization on paper, but is necessary to provide acute operative services.

C. Proposed ASTC Will Address the Health Care Needs of the Growing Arabic Population Living in Chicago's Southwest Suburbs.

Two studies are attached to this application that discuss the complex needs of Arab and Muslim American patients, and show how the health care system in the United States is failing to meet the needs of patient who adhere to the daily tenets of the Islamic faith. The studies explain how certain values and cultural practices of Arab and Muslim Americans play a significant role in community health disparities among this population group because negative experiences with western medicine are negatively influencing future health behaviors and healthcare-seeking patterns among this group of patients. In fact, in the geographic areas where there is a growing Arabic population, more and more examples arise that illustrate how our western health care system has yet to adapt to the challenges raised by patients who follow Islamic culture.

As of the 2010 decennial census, there are approximately 3 million Arab Americans living in the United States. According to U.S. Census Bureau data, about one of every three Arab Americans lives in one of the nation's six largest metropolitan areas. In fact, about 90 percent live in urban areas. The cities with largest Arab American populations are Los Angeles, Detroit, New York, Chicago and Washington, D.C.

In the Chicagoland area, there are two geographic areas where there is a notable concentration of persons of Arabic descent. The first area is the north side of the City of Chicago and into some near northwest suburbs such as Skokie, Illinois. Two maps are included with this Attachment 12 that illustrate the size of this Arabic population cluster. The first map, a zip code map for the City of Chicago, identifies the zip code areas with the largest Arabic populations that lie within the city limits. The areas highlighted in pink represent the top 10 zip code areas where persons of Arabic descent are living. The areas highlighted in orange show the next 10 most populous zip code areas with the highest concentration of persons who are identified as Arabic.

The second map included with this attachment is a zip code map illustrating the areas with the highest concentration of persons of Arabic descent living in Chicago's suburban communities. The extension of the north-side Arabic population cluster into suburbs like Skokie can be seen on this map.

The most significant population cluster in the suburban, and the most populous cluster in regards to persons of Arabic descent overall, is located in Chicago's southwest suburbs. This Arabic population cluster includes three zip code areas located within the City of Chicago that border or are near Oak Lawn, Illinois (see the City of Chicago zip code map). This area extends down through Orland Park, Illinois, and continues expanding towards Chicago's far south and southwest suburbs. Importantly, the proposed ASTC's site is located within this population cluster, and is ideally located in Orland Park as it is centrally located to the suburbs with the highest Arabic populations and the areas where population growth is likely to occur.

Future migration of Arabs into the south and southwest suburbs is likely because of the area's proximity to southeast Michigan. Southeast Michigan is home to one of the nation's longest-standing and largest Arab American population centers. Nearly 200,000 Arab Americans call

ATTACHMENT 12

Criterion 1110.230 -- Purpose of the Project

southeast Michigan home. As a result, the south and southwest suburbs offer an ideal location for any Arab family who has family or friends living in southeast Michigan or nearby in northwest Indiana. Thus, areas such as Orland Park, Illinois offer Arab families great access to the city by expressway or public transportation, but also quick access to expressways heading towards Indiana and Michigan.

As the attached maps illustrate, the most notable Arab population cluster is found in Chicago's southwest suburbs, with most of the zip code areas with significant Arabic population located within the proposed GSA. The continued migration of Arab and Muslim Americans to the south and southwest makes Orland Park, Illinois the ideal location to establish a health care facility that is designed to meet the needs of this growing population group.

D. Location is Important, But Proper Design, Adequately Trained and Bi-Lingual Staff Are Essential

Beyond location, another element critical to establishing a health care facility that will treat Arab and Muslim Americans, is to provide a health care facility that is designed to be culturally sensitive to Arab Americans, but just as important, has staff who are sufficiently trained and understand the cultural needs of these Arab and Muslim Americans. In addition, it will be essential to have multi-lingual staff who speak Arabic, the main language of this population group.

(a) Proper Design

Most American health care facilities are not designed with Arabic patients in mind, specifically Muslim Americans who have very specific needs and desires in regards to the delivery of health care services. In fact, the Applicant is not aware of any health care facility in Illinois that has been designed using the cultural values of Arab and Muslim Americans to guide the design and development process. Therefore, CON approval would make the proposed ASTC a first-of-its-kind. In order to design a health care facility that complies with Arab and Muslim culture, the Applicant needs to include certain adjustments to the clinical and non-clinical areas of the facility. For example, a culturally sensitive ASTC will need to make accommodations to address the following needs:

- Additional space is necessary to allow for Muslim's daily prayers. Prayer is required in Islam five times a day; therefore, it is important to incorporate sufficient space into design to accommodate patients, staff and physicians who desire to meet their daily prayer obligations at the required times each day.
- Adequate washing facilities are also essential. Each prayer session must be preceded by a ritual ablution. This ablution, or "washing", is called wudu' and is intended to purify one's bad acts by washing hands, feet and face. As a result, the ASTC will include additional washing areas.
- Additional walls and partitions are planned to be constructed in order to provide an enhanced level of privacy when compared with your typical surgery center.

(b) Addressing the Needs of Arab and Muslim American Patients

Two studies are included with this attachment that reveal some of the challenges faced by patients who practice the Islamic faith (see citations A and B below). For example, these studies revealed the following:

ATTACHMENT 12

Criterion 1110.230 -- Purpose of the Project

- Muslims who participated in the study said that in most U.S. health care settings, Arab and Muslim Americans often run the risk of being treated negatively by physicians and health care facility staff when they request accommodations based on their religious and cultural beliefs.
- Other participants described U.S. health care facilities as "unwelcoming" and often create hostile or unfriendly environments that result in Arab and Muslim Americans choosing to avoid accessing health care services in the future. Consequently, future decisions to forgo needed health care services could be harmful or fatal if a prior experience leads a person to avoid seeing a doctor or visiting the local hospital where untrained staff are employed or have an unwillingness to make accommodations. In sum, Arab and Muslim Americans who have negative experiences at U.S. health care facilities can negatively influence their future health care decision-making, which could lead to more severe and/or more costly health care services.
- Participants added that obtaining health care services from a provider of the same gender is very important. However, many health care facilities, even those located in Arabic population centers, are not aware of this major religious tenet, and for those providers that were aware, it is common to find periods of time where facility staff are only fully one gender and same-sex staff and practitioners are not readily available.

Based on these sentiments, the Applicant plans to employ staff and engage physicians to work at the ASTC who understand the Middle Eastern medical context and each patient's specific country of origin because it is in these environments where many Arab and Muslim Americans formed their attitudes, beliefs and practices towards obtaining and receiving health care services. By gaining this knowledge on every patient, Arab and Muslim American patients served at the proposed ASTC will be treated appropriately throughout every stage of their medical procedures, a fact which should encourage positive decision-making when future health care treatments become necessary.

There is nothing improper with designing a healthcare facility that focuses on a particular demographic group. The State Board often considers factors such as language, ethnicity, and economic status when considering pending CON permit applications. The State Board often finds that having health care staff who are fluent in a key language is an important factor to consider when deciding to approve a newly proposed surgery center.

In December 2012, the State Board approved a multi-specialty surgery center that verbally stated one of its goals was to serve Russian Americans, and to have staff fluent in Russian as bilingual staff was identified as an impediment to this demographic group receiving adequate health care services. See CON Project 12-076. The Hispanic American Endoscopy Center is another good example of a surgery center that was approved by the State Board because it intended to serve Hispanic Americans and provide staff fluent in Spanish and English. It has been proven that one way to significantly combat disparities in healthcare is having bilingual staff. Many studies have shown that making accommodations for patients' language needs can help reduce racial and ethnic disparities in healthcare.

E. Multi-Specialty ASTC Will Ensure That Arabic Patients Have the Opportunity to Access to the Full Spectrum of Surgical Services.

Although this CON permit application includes physician referral letters for six surgical specialties, the Applicant hopes to continue recruiting physicians who are sensitive to the needs

ATTACHMENT 12

Criterion 1110.230 -- Purpose of the Project

of Arabic patients and who can provide a wider array of services so that Arab and Muslim patients in need of surgical services can obtain those services at a facility that is culturally sensitive to Arab and Muslim Americans as quick as possible. This is important because there are no alternatives to the proposed ASTC that offer the same level of care and attention that is desired by Arab and Muslim American patients. Therefore, it is critical that this ASTC be allowed to expand its services without future CON approval as additional regulatory delays could restrict or hinder access to essential health care services.

G. Accommodating the Muslim-American Population Will Not Alienate Non-Muslim Patients.

The Applicant's plan to accommodate Arab and Muslim American patients, and to design the ASTC in a manner that accommodates the cultural needs of Arab and Muslim Americans, will not discourage non-Muslim patients from utilizing the ASTC. The Applicant intends to create a health care facility that appeals to the community as a whole, a place where persons of every race, color, ancestry, religion, sex, sexual orientation, age, handicap, marital status, parental status, military discharge status, or national origin feel welcome. Therefore, the ASTC will be designed with neutral décor and signage, and advertising campaigns that are likely to reach the community as a whole will be carefully crafted to ensure that wide-spread marketing efforts do not send a message or create any misconceptions that the ASTC is only for persons who are Arab and Muslim American. From the public's point of view, Preferred SurgiCenter should only be perceived as a state-of-the-art facility that provides high-quality health care services in a convenient outpatient setting.

4. The documents cited below, which are included immediately following this attachment, provide detailed information about the problems identified by the Applicant in the narrative above:
 - A. Adnan Hammad, Ph.D., et al., Guide to the Arab Culture: Health Care Delivery to the Arab American Community, ARAB COMMUNITY CENTER FOR ECONOMIC AND SOCIAL SERVICES (April 1999).
 - B. Aasim Padela, M.D., M.S., et al., Meeting the Needs of American Muslims: Challenges and Strategies for Healthcare Settings, INSTITUTE FOR SOCIAL POLICY AND UNDERSTANDING (June 2011).
 - C. A Health Care Provider's Guide to Islamic Religious Practices, COUNCIL ON AMERICAN-ISLAMIC RELATIONS (2005).
 - D. City of Chicago Zip Code Map: Arabic Population Centers in the City of Chicago.
 - E. Chicago Suburbs Zip Code Map: Arabic Population Centers in the Chicagoland Area.
 - F. U.S. Census Bureau Data: Zip Codes with the Highest Percentage of Arabs in Illinois, *available at ZipAtlas.com*, last visited February 1, 2013.
 - G. U.S. Census Bureau Data: Zip Codes with the Highest Percentage of Arabs in Illinois, *available at ZipAtlas.com*, last visited February 4, 2013.
 - H. U.S. Census Bureau Data: Arab Population in Selected Places (2000 Census).
5. As discussed above, no ASTC in the Chicagoland area is designed to address the cultural and language needs of Arab and Muslim Americans, employs staff and/or engages surgeons who are knowledgeable and respectful to the needs of Arab and Muslim American patients, and is able to

ATTACHMENT 12

Criterion 1110.230 -- Purpose of the Project

offer its patients the wide array of services typically offered at multi-specialty ASTCs. In addition, ASTCs are cost saving ventures in the context of Medicaid and Medicare reimbursement, which is important because the Applicant plans to enroll in both of these government-sponsored health care programs.

6. This project's goals are as follows: (i) to provide a cost-effective alternative to higher-cost hospital based care that appeals to persons of every faith and cultural background, (ii) to establish the first-ever ASTC that is sensitive to the cultural and language needs of Arab and Muslim Americans but also is a surgery center that appeals to the public as a whole, (iii) to provide educated and caring staff who can meet the needs of Arab and Muslim American patients residing in the southwest suburbs and provide health care services that respect the values of the Islamic culture, (iv) to create a health care setting where Arab and Muslim American patients are comfortable and encouraged to continue accessing health care services in the future, and (v) to increase access to surgical services to all persons living in the proposed GSA by providing a high-quality setting in a convenient location.

The Applicant firmly believes that caring for the sick and the weak is a collective, societal responsibility. Because of this belief, the Applicant will also enroll in the Medicaid program and offer a robust charity care program at the surgery center. We will have a variety of initiatives in place to help individuals who live in the communities we serve access affordable health care. We will offer services and programs to assist patients who are uninsured or underinsured. We will make all reasonable efforts to care for as many of our service area's needy patients as we are financially able to accommodate.

7. In addition to the foregoing, the project involves the modernization of existing space, which will have a net positive effect on the community of Orland Park, Illinois. First, the project will lead to the continued development of unused retail space, creating a new business in the community that provides new jobs for the area and generating additional tax revenue for the Village of Orland Park. This is a good step for a community that witnessed Plunkett Furniture, the former tenant of the building in which the ASTC will be located, go out of business after providing the area resident's with home furnishings for nearly 100 years. It will be good for the community to see unused space be converted to a business that provides a beneficial service to the area's residents. Moreover, a new health care provider, centrally located in the southwest suburbs in an area with easy access to major transportation routes, will have a positive effect because the ASTC will create enhanced access to health care services.

[This Page Intentionally Left Blank]

ATTACHMENT 12

Criterion 1110.230 -- Purpose of the Project

73

ATTACHMENT 13

Criterion 1110.230 -- Alternatives

Pursuant to 77 Ill. Adm. Code § 1110.230(c), Preferred SurgiCenter, LLC (the "Applicant") considered the following alternatives to the proposed project:

1. Do Nothing.

The first alternative considered by the Applicant was to maintain the status quo and forgo the establishment of a new ambulatory surgical treatment center ("ASTC") in Orland Park, Illinois.

Total Project Cost: \$0

Reason(s) for Rejecting Alternative:

The Applicant rejected this alternative because it does not address the health care needs of the Arabic and non-Arabic residents of the geographic service area ("GSA"). Furthermore, the absence of a health care facility that is culturally sensitive to Arab and Muslim Americans in the Chicagoland area would mean that Arab and Muslim Americans would continue to receive care that does not fully account for their cultural values.

2. Utilize Existing Providers.

Another alternative considered by the Applicant was to utilize an existing provider instead of establishing a new ASTC.

Total Project Cost: Undetermined

Reason(s) for Rejecting Alternative:

The Applicant determined it would be an easier to develop a new health care facility that would meet the needs of Arab and Muslim Americans by itself rather than taking the time and extra effort required to find an ideal partner or partners who would fully understand the needs of Arab and Muslim American patients and be willing to make the necessary changes at their existing health care facility to achieve the goals desired by the Applicant. By pursuing the project alone, the ASTC will likely be developed and operational much sooner than expected when compared with the potential amount of time to create a partnership with mutual goals and desires. In addition, the Applicant was concerned that the staff employed at nearby hospitals are not adequately trained to serve Arab and Muslim American patients and that hospital partners may not have been willing to commit the time and resources necessary to accomplish the goals intended for this project. For these reasons, this alternative was rejected by the Applicant.

3. **Establish an ASTC at an Alternate Location.**

The Applicant also considered establishing an ASTC at an alternate location.

Total Project Cost: \$7,500,000 to \$10,000,000

Reason(s) for Rejecting Alternative:

The Applicant selected the Orland Park, Illinois site because it was the best location that could be found for the intended purpose. It is centrally-located among growing population centers where Arab and Muslim Americans live, the space available is easily adaptable and does not present many limitations on what can be accomplished in the available space, and the modernization of this space helps continue the redevelopment of a property that became vacant in 2009 after the original occupant, Plunkett Furniture, went out of business. Moreover, modernization costs are generally lower than building a new facility from the ground up. This latter alternative would have required the acquisition of land and new construction, which would have likely resulted in a total project cost much higher than the modernization costs seen in this project. The additional design and building components could have increased the cost of this project anywhere from 50% to 100% of the current project cost.

Documentation and Evidence

As discussed in the alternatives narrative provided above, the Applicant considered several alternative options before submitting the present CON permit application. The narrative above compares the various alternatives considered by the Applicant and, pursuant to the State Board's rules, each one considered the costs and other necessary factors relevant to each alternative. In cases where the Applicant was not able to determine the cost of a stated alternative option, "undetermined" is provided next to the project cost for the given alternative.

Empirical Evidence & Data

The Applicant is instructed to provide, if available, empirical evidence, including quantified outcome data, which verifies improved quality of care will occur if the project is approved. The following studies provide evidence that a health care facility that operates in a manner that properly addresses the needs and desires of Arab and Muslim American patients can enhance the quality of patient care and encourage behavior that results in the patient seeking further medical services in the future. Copies of these studies are provided along with Attachment 12, which immediately precedes this attachment. The two studies are as follows:

- A. Adnan Hammad, Ph.D., et al., Guide to the Arab Culture: Health Care Delivery to the Arab American Community, ARAB COMMUNITY CENTER FOR ECONOMIC AND SOCIAL SERVICES (April 1999).
- B. Aasim Padela, M.D., M.S., et al., Meeting the Needs of American Muslims: Challenges and Strategies for Healthcare Settings, INSTITUTE FOR SOCIAL POLICY AND UNDERSTANDING (June 2011).

ATTACHMENT 13

Criterion 1110.230 -- Alternatives

171

ATTACHMENT 14

Criterion 1110.234 -- Project Scope: Size of Project

Size Of Project				
Department/ Service	Proposed BGSF/DGSF	State Standard	Difference	Met Standard?
ASTC	8,800 DGSF	8,800 DGSF	0	YES

The State Standard for a proposed ambulatory surgical treatment center ("ASTC") is between 1,660 and 2,200 department gross square feet ("DGSF") per Treatment Room. Preferred SurgiCenter, LLC ("Applicant") is proposing to establish an ASTC with four (4) Treatment Rooms, consisting of three (3) operating rooms and one (1) procedure room (collectively, the "Project").

The Project will be a modernization that builds out leased space, with the interior being built out by the Applicant. Because the Project is classified as a modernization, the proper measure of square footage under the rules of the Illinois Health Facilities and Services Review ("State Board") is departmental gross square feet (i.e., DGSF). The proposed 8,800 DGSF amounts to 2,200 DGSF per ASTC Treatment Room, and therefore, meets the State Board's applicable standard.

ATTACHMENT 15

Criterion 1110.234 -- Project Services Utilization

Utilization					
	Dept./ Service	Historical Utilization (Patient Days) (Treatments) Etc.	Projected Utilization	State Standard 1,500 HRS x #ORs	Met Standard?
Year 1	ASTC	6,383 Procedures	9,441.0 Hours	6,000.0 Hours	YES
Year 2	ASTC	6,383 Procedures	9,441.0 Hours	6,000.0 Hours	YES

As the chart above illustrates, by the second year following project completion, the anticipated utilization for the proposed ambulatory surgical treatment center (the "ASTC") will meet the total number of surgical hours required by the applicable state standard. The State Board's rules, specifically 77 Ill. Adm. Code 1110.Appendix B, provides that utilization standards are 1,500 hours of surgical time per "treatment room" (i.e., an operating/procedure room).

For all surgical procedures other than podiatry, the average number of hours per procedure will be 1.5 hours/procedure, which is the typical average for multi-specialty surgery centers. This average amount of time includes time for surgery preparation and post-procedure clean up. Historical utilization by the referring physicians, coupled with modest increases in physician referral numbers due to the hiring of additional surgeons by the referring physicians, is expected to yield 6,116 procedures at an average time of 1.5 hours per procedure. Therefore, based on the anticipated number of surgical cases that will be referred to the proposed ASTC, over 9,174.0 hours of surgery time is expected by the end of the second year of operation.

For podiatry, the average number of hours per procedure will be 1.0 hour/procedure, which is the typical average for multi-specialty surgery centers. This average amount of time includes time for surgery preparation and post-procedure clean up. Historical utilization by the referring physicians, coupled with modest increases in physician referral numbers due to the hiring of additional surgeons by the referring physicians, is expected to yield 267 procedures at an average time of 1.0 hour per procedure. Therefore, based on the anticipated number of surgical cases that will be referred to the proposed ASTC, over 267 hours of surgery time is expected by the end of the second year of operation.

This is enough volume to justify six treatment rooms, while the Applicant is only seeking approval for four treatment rooms. Accordingly, this application demonstrates sufficient volume to support the four proposed procedure rooms.

Note: Additional information pertaining to project patient volumes is provided at Attachment 27, which addresses Criterion 1110.1540(c).

ATTACHMENT 27

**Criterion 1110.1540(c)
Projected Patient Volume**

The physician referral letters supporting the proposed ASTC provide the number of patients referred to health care facilities (ASTCs and Hospitals) within the past 12 months and the project referrals to the proposed ASTC during the first full year of operation. The following chart also identifies the facilities to which the referring physicians sent patients to during calendar year 2012 and the number of referrals that each physician anticipates referring to the ASTC once it becomes operational.

Specialty	Physician Name	Hospital/ASTC	# Cases Performed in Past 12 Months	Anticipated # Cases Referred to New ASTC	
Gastroenterology	R. Rotnicki, M.D.	Surgery Center of Joliet, Joliet, IL	552	500	
		St. Joseph Medical Center, Joliet, IL	64		
		SUBTOTALS	616	500	
	B. Hamad, M.D.	Silver Cross Hospital, Joliet, IL	235	700	
		Surgery Center of Joliet, Joliet, IL	547		
		St. Joseph Medical Center, Joliet, IL	420		
		SUBTOTALS	1,202	700	
	R. Manglano, M.D.	MetroSouth Medical Center, Blue Island, IL	208	300	
		Pronger Smith, Tinley Park, IL	360		
		SUBTOTALS	568	300	
	E. Vargas, M.D.	St. Mary's Hospital, Chicago, IL	360	295	
		Fullerton Surgery Center, Chicago, IL	176		
SUBTOTALS		536	295		
General Surgery	R. Manglano, M.D.	Palos Community Hospital, Palos Heights, IL	50	100	
		Metro South Medical Center, Blue Island, IL	816		
		Pronger Smith Center, Blue Island, IL	48		
		Pronger Smith Center, Tinley Park, IL	336		
		SUBTOTALS	1,250		100
	T. Diniotis, M.D.	Our Lady of Resurrection Hospital, Chicago, IL	550	350	
		Thorek Memorial Hospital, Chicago, IL	200		
		Fullerton Surgery Center, Chicago, IL	79		
		SUBTOTALS	829	350	
	S. Bittar, M.D.	Tinley Woods Surgical Center, Tinley Park, IL	80	150	
		Hinsdale Surgery Center, Hinsdale, IL	150		
		LaGrange Memorial Hospital, LaGrange, IL	400		
		Hinsdale Hospital, Hinsdale, IL	150		
		Ingalls Memorial Hospital, Harvey, IL	320		
		SUBTOTALS	1,100		150
	Podiatry	M. Maghrabi, DPM	St. Mary & Elizabeth Hospital, Chicago, IL	356	267
			SUBTOTALS	356	267
	Obstetrics / Gynecology	K. Jobanputra, M.D.	Holy Cross Hospital, Chicago, IL	300	144
SUBTOTALS			300	144	
T. Tarsha, M.D.		Saints Mary & Elizabeth Hospital, Chicago, IL	1,756	702	
		SUBTOTALS	1,756	702	
Orthopedics	G. Primus, M.D.	Advocate South Suburban Hospital, Hazel Crest, IL	113	250	
		MetroSouth Medical Center, Blue Island, IL	63		
		Minimally Invasive Surgery Center, Mokena, IL	59		
		St. Anthony's Hospital, Chicago, IL	57		
		Dearborn Medical Consultants, Chicago, IL	23		
		SUBTOTALS	315		250
Pain Management	Y. Hussein, M.D.	AmSurg Surgery Center, Joliet, IL	150	525	
		Fullerton Surgery Center, Chicago, IL	240		
		Orland Park Surgery Center, Orland Park, IL	150		
		SUBTOTALS	540		525
	T. King, M.D.	Tinley Woods Surgical Center, Tinley Park, IL	500	1,685	
		Physician Office, Orland Park, IL	960		
		SUBTOTALS	1,460		2,100
TOTALS			10,828	6,383	

NOTE: Copies of the physician referral letters immediately follow this page; however, the original physician referral letters (original, signed copies) are attached to this application as Appendix I.

Page Deleted by Type B Modification

March 15, 2013

Page Deleted by Type B Modification

March 15, 2013

The following pages include copies of two letters discussing a Type B modification, which was addressed in the initial letter submitted to the State Board on March 14, 2013.

194A

Holland & Knight

131 South Dearborn Street | Chicago, IL 60603 | T 312.263.3600 | F 312.578.6666
Holland & Knight LLP | www.hklaw.com

Joseph Hylak-Reinholtz
(312) 715-5885
jhreinholtz@hklaw.com

March 14, 2013

Via Electronic Mail to "mike.constantino@illinois.gov"

Mr. Mike Constantino
Supervisor, Project Review Section
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

Re: Preferred SurgiCenter, LLC (CON Project No. 13-007)

Dear Mr. Constantino:

This letter provides notice to the Illinois Health Facilities and Services Review Board (the "State Board") of a Type B modification as specified in Section 1130.650(b) of the State Board's rules. Specifically, this letter provides written notice of a modification being made by Preferred SurgiCenter, LLC (the "Applicant") to its certificate of need ("CON") permit application (CON Project No. 13-007). A Type B modification is necessary because Dr. Mihir Majmundar, one of the referring physicians who specializes in gastroenterology, is withdrawing from the project. In addition, new referring physicians are replacing Dr. Majmundar's anticipated caseload.

In his referral letter, Dr. Majmundar stated that he performed 2,420 gastroenterology surgical cases over the 12 month period immediately preceding the filing of the CON permit application. Dr. Majmundar also indicated that he would refer 1,645 gastroenterology surgical cases to the surgery center proposed by the Applicant.

As of the date of this notice letter, the Applicant has received patient referral letters from two new physicians that will replace the anticipated surgical caseload that was lost as a result of Dr. Majmundar's withdrawal. Duplicate copies of these two replacement letters are enclosed with this letter. The original copies of these letters will be sent to the State Board in a separate mailing from the Applicant. The two physicians, Dr. Bashar Hamad and Dr. Richard Rotnicki, will collectively refer 1,200 gastroenterology surgical cases to the proposed surgery center. Dr. Hamad will refer 700 cases to the proposed surgery center and Dr. Rotnicki will refer 500 cases to the proposed surgery center.

The Applicant will submit additional physician referral letters to the State Board soon, which will address the remaining 445 case shortfall created by the withdrawal of Dr. Majmundar. It is my understanding that these physicians will also specialize in gastroenterology, and if not,

194B

March 14, 2013
Replacement Physician Referral Letters, Project 13-007.
Page 2 of 2

will specialize in one of the other two categories of surgery being sought by the Applicant in its CON permit application.

If you have questions about this notice letter, or need additional information, please do not hesitate to contact me at (312) 715-5885. Thank you for your consideration.

Sincerely yours,

HOLLAND & KNIGHT, LLP



Joseph Hylak-Reinholtz

JHR/jhr

enclosures

MAR-07-2013 17:07

From:17732370785

3/7/13, 2013

Ms. Courtney Avery
Administrator
Illinois Health Facilities and Services Review Board
Illinois Department of Public Health
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

RE: Physician Referral Letter for Project No. 13-007, Preferred SurgiCenter, LLC

Dear Ms. Avery:

I am a surgeon who specializes in gastroenterology ("Specialty"). Over the past twelve months, I have performed a total of 616 outpatient surgery cases in this Specialty. My surgical caseload in this Specialty will constitute the majority of my surgical work in the future.

During the past twelve months, I referred my surgical cases in this Specialty to the following health care facilities, which includes hospitals and ambulatory surgical treatment centers ("ASTC"). I expect to refer a certain number of these surgical cases to the multi-specialty ASTC that will be operated by Preferred SurgiCenter, LLC (the "CON Permit Applicant"). The referred patients will reside within the CON Permit Applicant's proposed geographic service area.

Name & Address of Healthcare Facility	Type of Healthcare Facility: ASTC, Hospital or Other	Number of Surgical Cases Referred to HCF: Most Recent 12 Month Period
Name: Silver Cross Hospital Address: Joliet IL	hospital	0
Name: Surgery Center of Joliet Address: Joliet IL	surgy cntr	552
Name: St Joseph med Cntr Address: Joliet IL	hosp.	64
Name: Address:		
TOTALS		<u>616</u>

Based on my prior surgical caseload, I anticipate that I will refer 500 surgical cases in my Specialty to the proposed ASTC.

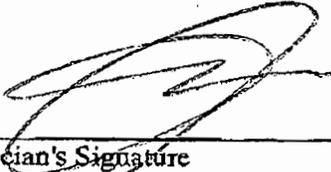
194 D

Physician Referral Letter
Preferred SurgiCenter, LLC (Project No. 13-007)
Page 2

I certify that the aforementioned referrals have not been used to support another pending or approved certificate of need permit application. The information provided in this letter is true and correct to the best of my knowledge.

In addition to the referral information provided herein, please also note my strong support for the proposed ASTC.

Respectfully submitted,



Physician's Signature

Richard Rotnicki DO

Physician's Printed Name

1715 N DIVISION ST, Ste. A

Street Address

Morris IL 60450

City, State & Zip Code

NOTARY:

Subscribed and sworn to me this 14th day of MARCH, 2013.

Notary Public

Seal:



194 E

3/7/13, 2013

Ms. Courtney Avery
Administrator
Illinois Health Facilities and Services Review Board
Illinois Department of Public Health
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

RE: Physician Referral Letter for Project No. 13-007, Preferred SurgiCenter, LLC

Dear Ms. Avery:

I am a surgeon who specializes in gastroenterology ("Specialty"). Over the past twelve months, I have performed a total of 1202 outpatient surgery cases in this Specialty. My surgical caseload in this Specialty will constitute the majority of my surgical work in the future.

During the past twelve months, I referred my surgical cases in this Specialty to the following health care facilities, which includes hospitals and ambulatory surgical treatment centers ("ASTC"). I expect to refer a certain number of these surgical cases to the multi-specialty ASTC that will be operated by Preferred SurgiCenter, LLC (the "CON Permit Applicant"). The referred patients will reside within the CON Permit Applicant's proposed geographic service area.

Name & Address of Healthcare Facility	Type of Healthcare Facility: ASTC, Hospital or Other	Number of Surgical Cases Referred to HCF: Most Recent 12 Month Period
Name: Silver Cross Hospital Address: Joliet IL	Hosp	235
Name: Surgery Center of Joliet Address: Joliet IL	Surg cntr	547
Name: St Joseph med Cntr Address: Joliet IL	hosp.	420
Name: Address:		
TOTALS		1202

Based on my prior surgical caseload, I anticipate that I will refer 700 surgical cases in my Specialty to the proposed ASTC.

194 F

Physician Referral Letter
Preferred SurgiCenter, LLC (Project No. 13-007)
Page 2

I certify that the aforementioned referrals have not been used to support another pending or approved certificate of need permit application. The information provided in this letter is true and correct to the best of my knowledge.

In addition to the referral information provided herein, please also note my strong support for the proposed ASTC.

Respectfully submitted,

B. Hamad

Physician's Signature

Bashar Hamad MD

Physician's Printed Name

1100 Howbolt Rd

Street Address

Joliet IL 60431

City, State & Zip Code

NOTARY:

Subscribed and sworn to me this 7th day of March, 2013.

Toni Durham

Notary Public

Seal:



Holland & Knight

131 South Dearborn Street | Chicago, IL 60603 | T 312.263.3600 | F 312.578.6666
Holland & Knight LLP | www.hklaw.com

Joseph Hylak-Reinholtz
(312) 715-5885
jhreinoltz@hklaw.com

March 28, 2013

Via Electronic Mail to "mike.constantino@illinois.gov"

Mr. Mike Constantino
Supervisor, Project Review Section
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

Re: Preferred SurgiCenter, LLC (CON Project No. 13-007)

Dear Mr. Constantino:

This letter provides additional information related to the letter, dated March 14, 2013, which notified the Illinois Health Facilities and Services Review Board (the "State Board") of a Type B modification affecting the certificate of need ("CON") permit application submitted by Preferred SurgiCenter, LLC (the "Applicant"). Specifically, this letter provides the final two replacement physician referral letters, which replace the referral volume lost when the Applicant was notified by a referring physician that he was no longer able to participate in the project.

Since March 14, the Applicant has received a total of four physician referral letters that are intended to replace the surgical volume lost due to the original physician's withdrawal. The Applicant sent copies of the first two replacement referral letters with the March 14 notice sent to the State Board, with the original letters being submitted shortly thereafter. The remaining two replacement physician referral letters (original versions) are also being mailed directly to the State Board, to your attention.

In the meantime, duplicate copies of the final two replacement letters are enclosed with this letter. The final two replacement physician referral letters are from the following physicians: (1) Ramon Manglano, M.D. (300 gastroenterology referrals) and (2) Sami Bittar, M.D. (150 general surgery referrals). Taken together with the March 14 replacement physician referral letters (i.e., the letters from Bashar Hamad, M.D. and Richard Rotnicki, M.D.), the Applicant has fully replaced the procedures lost by the withdrawal of the original referring physician.

In addition to the replacement letters attached hereto, the Applicant also submits a page to replace Page 182 of the CON permit application. In particular, the new page presents a revised chart detailing the number and type of physician referrals to be made to the proposed surgery center and is based upon the most current list of referring physicians. The chart is provided for Attachment 27, Criterion 1110.1540(c), Projected Patient Volume.

194 H

March 28, 2013
Replacement Physician Referral Letters, Project 13-007.
Page 2 of 2

If you have questions about this letter, or need additional information, please do not hesitate to contact me at (312) 715-5885. Thank you for your consideration.

Sincerely yours,

HOLLAND & KNIGHT, LLP

A handwritten signature in black ink, appearing to read 'JHR', followed by a long horizontal flourish.

Joseph Hylak-Reinholtz

JHR/jhr

enclosures

ATTACHMENT 27

**Criterion 1110.1540(c)
Projected Patient Volume**

The physician referral letters supporting the proposed ASTC provide the number of patients referred to health care facilities (ASTCs and Hospitals) within the past 12 months and the project referrals to the proposed ASTC during the first full year of operation. The following chart also identifies the facilities to which the referring physicians sent patients to during calendar year 2012 and the number of referrals that each physician anticipates referring to the ASTC once it becomes operational.

Specialty	Physician Name	Hospital/ASTC	# Cases Performed in Past 12 Months	Anticipated # Cases Referred to New ASTC
Gastroenterology	R. Rotnicki, M.D.	Silver Cross Hospital, Joliet, IL	0	500
		Surgery Center of Joliet, Joliet, IL	552	
		St. Joseph Medical Center, Joliet, IL	64	
		SUBTOTALS	616	
	B. Hamad, M.D.	Silver Cross Hospital, Joliet, IL	235	700
		Surgery Center of Joliet, Joliet, IL	547	
		St. Joseph Medical Center, Joliet, IL	420	
		SUBTOTALS	1,202	
	R. Manglano, M.D.	MetroSouth Medical Center, Blue Island, IL	208	300
		Pronger Smith, Tinley Park, IL	360	
		SUBTOTALS	568	
	E. Vargas, M.D.	St. Mary's Hospital, Chicago, IL	360	295
		Fullerton Surgery Center, Chicago, IL	176	
SUBTOTALS		536	295	
General Surgery	R. Manglano, M.D.	Palos Community Hospital, Palos Heights, IL	50	100
		Metro South Medical Center, Blue Island, IL	816	
		Pronger Smith Center, Blue Island, IL	48	
		Pronger Smith Center, Tinley Park, IL	336	
		SUBTOTALS	1,250	
	T. Diniotis, M.D.	Our Lady of Resurrection Hospital, Chicago, IL	550	350
		Thorek Memorial Hospital, Chicago, IL	200	
		Fullerton Surgery Center, Chicago, IL	79	
		SUBTOTALS	829	
	S. Bittar, M.D.	Tinley Woods Surgical Center, Tinley Park, IL	80	150
		Hinsdale Surgery Center, Hinsdale, IL	150	
		LaGrange Memorial Hospital, LaGrange, IL	400	
		Hinsdale Hospital, Hinsdale, IL	150	
		Ingalls Memorial Hospital, Harvey, IL	320	
		SUBTOTALS	1,100	
Pain Management	Y. Hussein, M.D.	AmSurg Surgery Center, Joliet, IL	150	525
		Fullerton Surgery Center, Chicago, IL	240	
		Orland Park Surgery Center, Orland Park, IL	150	
		SUBTOTALS	540	
	F. Rahman, M.D. & T. King, M.D.	Tinley Woods Surgical Center, Tinley Park, IL	500	1,685
		Physician Office, Orland Park, IL	960	
		SUBTOTALS	1,460	
TOTALS			8,101	5,020

NOTE: Copies of the physician referral letters immediately follow this page; however, the original physician referral letters (original, signed copies) are attached to this application as Appendix 1.

ATTACHMENT 27

Criterion 1110.1540(c) -- Projected Patient Volume

182 194 J

March 27, 2013

Ms. Courtney Avery
Administrator
Illinois Health Facilities and Services Review Board
Illinois Department of Public Health
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

RE: Physician Referral Letter for Project No. 13-007, Preferred SurgiCenter, LLC

Dear Ms. Avery:

I am a surgeon who specializes in gastroenterology (endoscopy) surgery ("Specialty"). Over the past twelve months, I have performed a total of 568 outpatient surgery cases in this Specialty. My surgical caseload in this Specialty will constitute the majority of my surgical work in the future.

During the past twelve months, I referred my surgical cases in this Specialty to the following health care facilities, which includes hospitals and/or ambulatory surgical treatment centers ("ASTCs"). I expect to refer a certain number these surgical cases to the multi-specialty ASTC that will be operated by Preferred SurgiCenter, LLC (the "CON Permit Applicant"). The referred patients will reside within the CON Permit Applicant's proposed geographic service area.

Name & Address of Healthcare Facility	Type of Healthcare Facility (ASTC, Hospital or Other)	Number of Surgical Cases Referred to HCF Most Recent 12 Month Period
MetroSouth Medical Center 12935 South Gregory Street Blue Island, Illinois 60406	Hospital	208
Pronger Smith 17495 South LaGrange Road Tinley Park, Illinois 60487	Office	360
TOTALS		568

Based on my prior surgical caseload, I anticipate that I will refer 300 surgical cases in my Specialty to the proposed ASTC.

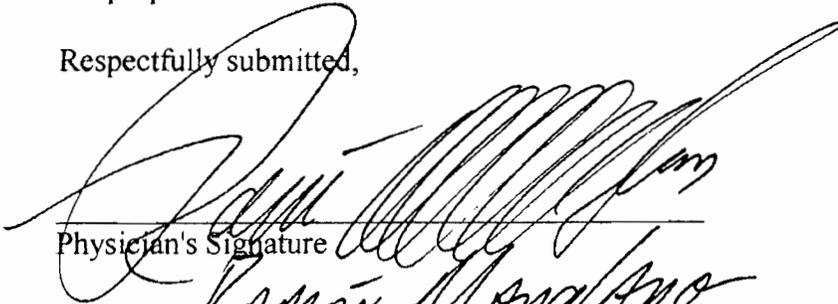
194 K

Physician Referral Letter
Preferred SurgiCenter, LLC (Project No. 13-007)
Page 2

I certify that the aforementioned referrals have not been used to support another pending or approved certificate of need permit application. I further certify that the information provided in this letter is true and correct to the best of my knowledge.

In addition to the referral information provided herein, please also note my support for the proposed ASTC.

Respectfully submitted,



Physician's Signature

Ramon Mangano

Physician's Name

2320 W. High St.

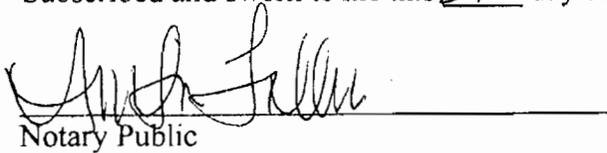
Street Address

Blue Island, IL

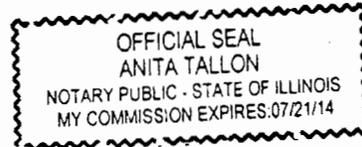
City, State & Zip Code

NOTARY:

Subscribed and sworn to me this 27th day of MARCH, 2013.



Notary Public



Seal:

March 22, 2013

Ms. Courtney Avery
Administrator
Illinois Health Facilities and Services Review Board
Illinois Department of Public Health
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

RE: Physician Referral Letter for Project No. 13-007, Preferred SurgiCenter, LLC

Dear Ms. Avery:

I am a surgeon who specializes in general surgery ("Specialty"). Over the past twelve months, I have performed a total of 1100 outpatient surgery cases in this Specialty. My surgical caseload in this Specialty will constitute the majority of my surgical work in the future.

During the past twelve months, I referred my outpatient surgical cases to the following health care facilities, which includes hospitals and/or ambulatory surgical treatment centers ("ASTCs"). I expect to refer a certain number these surgical cases to the multi-specialty ASTC that will be operated by Preferred SurgiCenter, LLC (the "CON Permit Applicant"). The referred patients will reside within the CON Permit Applicant's proposed geographic service area.

Name & Address of Healthcare Facility	Type of Healthcare Facility (ASTC, Hospital or Other)	Number of Surgical Cases Referred to HCF Most Recent 12 Month Period
Tinley Woods Surgery Center 18200 LaGrange Road Tinley Park, Illinois 60487	ASTC	80
Hinsdale Surgery Center 908 North Elm Street Hinsdale, Illinois 60521	ASTC	150
LaGrange Memorial Hospital 5101 Willow Springs Road LaGrange, Illinois 60525	Hospital	400
Hinsdale Hospital 120 North Oak Street Hinsdale, Illinois 60521	Hospital	150
Ingalls Memorial Hospital 1 Ingalls Drive Harvey, Illinois 60426	Hospital	320
TOTALS		1100

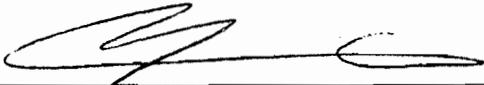
Based on my prior surgical caseload, I anticipate that I will refer 150 surgical cases in my Specialty to the proposed ASTC.

194 M

I certify that the aforementioned referrals have not been used to support another pending or approved certificate of need permit application. I further certify that the information provided in this letter is true and correct to the best of my knowledge.

In addition to the referral information provided herein, please also note my support for the proposed ASTC.

Respectfully submitted,



Physician's Signature

Dr. Sami M. Bittar

5201 S. Willow Springs Rd
Street Address

State 440 La Grange IL 60525
City, State & Zip Code

NOTARY:

Subscribed and sworn to me this 25th day of MARCH, 2013.


Notary Public

Seal:



The following letters are physician referral certification letters for the new categories of service being sought by the Applicant.

Dr. Michael Munir Maghrabi
2222 W. Division St., Suite 105
Chicago, Illinois 60622

July 10, 2013

Ms. Courtney Avery
Administrator
Illinois Health Facilities and Services Review Board
Illinois Department of Public Health
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

RE: Physician Referral Letter for Project No. 13-007, Preferred SurgiCenter, LLC

Dear Ms. Avery:

I am a surgeon who specializes in Podiatry ("Specialty"). Over the past twelve months, I have performed a total of 356 outpatient surgery cases in this Specialty. My surgical caseload in this Specialty will constitute the majority of my surgical work in the future.

During the past twelve months, I referred my surgical cases in this Specialty to the following health care facilities, which includes hospitals and/or ambulatory surgical treatment centers ("ASTCs"). I expect to refer a certain number these surgical cases to the multi-specialty ASTC that will be operated by Preferred SurgiCenter, LLC (the "CON Permit Applicant"). The referred patients will reside within the CON Permit Applicant's proposed geographic service area.

Name & Address of Healthcare Facility	Type of Healthcare Facility (ASTC, Hospital or Other)	Number of Surgical Cases Referred to HCF Most Recent 12 Month Period
Saints Mary and Elizabeth Medical Center 2233 West Division Street Chicago, Illinois 60622	Hospital	356
TOTALS		356

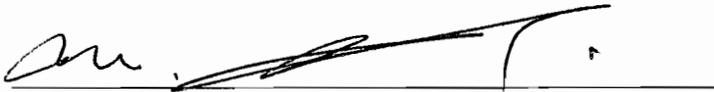
Based on my prior surgical caseload, I anticipate that I will refer 267 surgical cases in my Specialty to the proposed ASTC.

194 P

I certify that the aforementioned referrals have not been used to support another pending or approved certificate of need permit application. I further certify that the information provided in this letter is true and correct to the best of my knowledge.

In addition to the referral information provided herein, please also note my support for the proposed ASTC.

Respectfully submitted,



Dr. Michael Munir Maghrabi
2222 W. Division St., Suite 105
Chicago, Illinois 60622

NOTARY:

Subscribed and sworn to me this 10th day of July, 2013.



Notary Public

Seal:



Dr. Ketan Jobanputra

June 6, 2013

Ms. Courtney Avery
Administrator
Illinois Health Facilities and Services Review Board
Illinois Department of Public Health
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

RE: Physician Referral Letter for Project No. 13-007, Preferred SurgiCenter, LLC

Dear Ms. Avery:

I am a surgeon who specializes in OB/GYN surgery ("Specialty"). Over the past twelve months, I have performed a total of 300 outpatient surgery cases in this Specialty. My surgical caseload in this Specialty will constitute the majority of my surgical work in the future.

During the past twelve months, I referred my surgical cases in this Specialty to the following health care facilities, which includes hospitals and/or ambulatory surgical treatment centers ("ASTCs"). I expect to refer a certain number these surgical cases to the multi-specialty ASTC that will be operated by Preferred SurgiCenter, LLC (the "CON Permit Applicant"). The referred patients will reside within the CON Permit Applicant's proposed geographic service area.

Name & Address of Healthcare Facility	Type of Healthcare Facility (ASTC, Hospital or Other)	Number of Surgical Cases Referred to HCF Most Recent 12 Month Period
Holy Cross Hospital 2701 West 68 th Street Chicago, Illinois 60629	Hospital	300
TOTALS		300

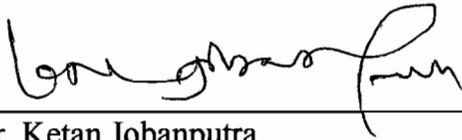
Based on my prior surgical caseload, I anticipate that I will refer 144 surgical cases in my Specialty to the proposed ASTC.

194 R

I certify that the aforementioned referrals have not been used to support another pending or approved certificate of need permit application. I further certify that the information provided in this letter is true and correct to the best of my knowledge.

In addition to the referral information provided herein, please also note my support for the proposed ASTC.

Respectfully submitted,



Dr. Ketan Jobanputra

1575 W. NAWB ST, #208
Address

HAMMERSHAW IL 60133
City, State, Zip Code

NOTARY:

Subscribed and sworn to me this 6th day of June, 2013.



Notary Public

Seal:



1945

Dr. Thana Tarsha
2222 W. Division St., Suite 330
Chicago, Illinois 60622

July 10, 2013

Ms. Courtney Avery
Administrator
Illinois Health Facilities and Services Review Board
Illinois Department of Public Health
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

RE: Physician Referral Letter for Project No. 13-007, Preferred SurgiCenter, LLC

Dear Ms. Avery:

I am a surgeon who specializes in OB/GYN surgery ("Specialty"). Over the past twelve months, I have performed a total of 1,756 outpatient surgery cases in this Specialty. My surgical caseload in this Specialty will constitute the majority of my surgical work in the future.

During the past twelve months, I referred my surgical cases in this Specialty to the following health care facilities, which includes hospitals and/or ambulatory surgical treatment centers ("ASTCs"). I expect to refer a certain number these surgical cases to the multi-specialty ASTC that will be operated by Preferred SurgiCenter, LLC (the "CON Permit Applicant"). The referred patients will reside within the CON Permit Applicant's proposed geographic service area.

Name & Address of Healthcare Facility	Type of Healthcare Facility (ASTC, Hospital or Other)	Number of Surgical Cases Referred to HCF Most Recent 12 Month Period
Saints Mary and Elizabeth Medical Center 2233 West Division Street Chicago, Illinois 60622	Hospital	1,756
TOTALS		1,756

Based on my prior surgical caseload, I anticipate that I will refer 702 surgical cases in my Specialty to the proposed ASTC.

194-T

I certify that the aforementioned referrals have not been used to support another pending or approved certificate of need permit application. I further certify that the information provided in this letter is true and correct to the best of my knowledge.

In addition to the referral information provided herein, please also note my support for the proposed ASTC.

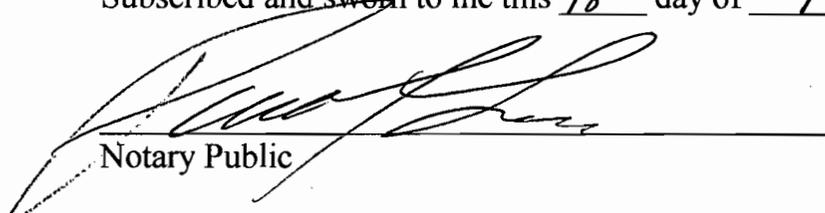
Respectfully submitted,



Dr. Thana Tarsha
2222 W. Division St., Suite 330
Chicago, Illinois 60622

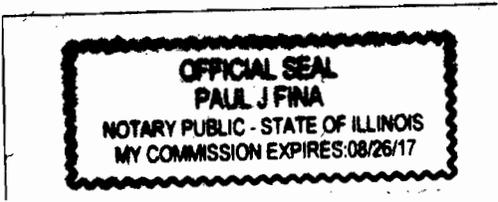
NOTARY:

Subscribed and sworn to me this 18th day of MAY, 2013.



Notary Public

Seal:



May 20, 2013

Ms. Courtney Avery
Administrator
Illinois Health Facilities and Services Review Board
Illinois Department of Public Health
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

RE: Physician Referral Letter for Project No. 13-007, Preferred SurgiCenter, LLC

Dear Ms. Avery:

I am a surgeon who specializes in orthopedic surgery ("Specialty"). Over the past twelve months, I have performed a total of 315 outpatient surgery cases in this Specialty. My surgical caseload in this Specialty will constitute the majority of my surgical work in the future.

During the past twelve months, I referred my surgical cases in this Specialty to the following health care facilities, which includes hospitals and/or ambulatory surgical treatment centers ("ASTCs"). I expect to refer a certain number these surgical cases to the multi-specialty ASTC that will be operated by Preferred SurgiCenter, LLC (the "CON Permit Applicant"). The referred patients will reside within the CON Permit Applicant's proposed geographic service area.

Name & Address of Healthcare Facility	Type of Healthcare Facility (ASTC, Hospital or Other)	Number of Surgical Cases Referred to HCF Most Recent 12 Month Period
Advocate South Suburban Hospital 17800 S. Kedzie Hazel Crest IL 60429	Hospital	113
Metro South Medical Center 12935 Gregory St. Blue Island IL 60424	Hospital	63
Minimally Invasive Surgery 19110 Barrin Dr. Mokena IL 60448	ASTC	59
St. Anthony's Hospital 2875 W. 19th Street CHICAGO IL 60628	Hospital	57
DEARBORN MEDICAL CONSULTANTS 712 N. DEARBORN, CHICAGO IL 60654	ASTC	23
TOTALS		315

Based on my prior surgical caseload, I anticipate that I will refer 250 surgical cases in my Specialty to the proposed ASTC.

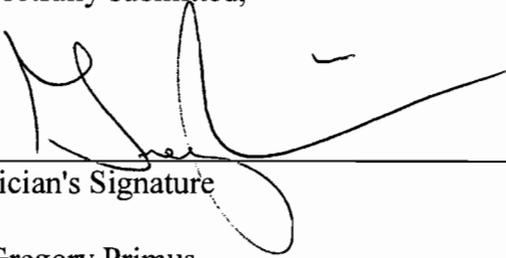
Physician Referral Letter
Preferred SurgiCenter, LLC (Project No. 13-007)

Page 2

I certify that the aforementioned referrals have not been used to support another pending or approved certificate of need permit application. I further certify that the information provided in this letter is true and correct to the best of my knowledge.

In addition to the referral information provided herein, please also note my support for the proposed ASTC.

Respectfully submitted,



Physician's Signature

Dr. Gregory Primus

18660 Graphics Drive Suite 100
Street Address

Tinley Park IL 60477
City, State & Zip Code

NOTARY:

Subscribed and sworn to me this 24th day of May, 2013.



Notary Public

Seal:



²
194. W

ATTACHMENT 27

**Criterion 1110.1540(d)
Treatment Room Need Assessment**

Number of Procedure Rooms Proposed

The Applicant is proposing to establish a multi-specialty ASTC with four (4) treatment rooms, which includes three (3) operating rooms and one (1) procedure room.

Estimated Time Per Procedure

For all surgical procedures other than podiatry, the Applicant estimates that the average length of time per procedure will be 1.5 hours, which includes thirty minutes of time for surgery preparation and post-surgery clean up.

For podiatry, the Applicant estimates that the average length of time per procedure will be 1.0 hour, which includes thirty minutes of time for surgery preparation and post-surgery clean up.

ATTACHMENT 27

**Criterion 1110.1540(f)
Establishment of New Facilities**

Services Proposed for New ASTC

1. Gastroenterology
2. General Surgery
3. Pain Management
4. Orthopedics
5. Obstetrics/Gynecology
6. Podiatry

Discussion

As noted in the "Purpose of the Project" narrative provided above as Attachment 12, the proposed project is necessary because the proposed services are not available in the geographic service area because no surgery center or hospital presently provides accommodations or facility design that meets the cultural needs of Arab and Muslim Americans. Consequently, the existing hospitals and surgery centers could be viewed as having restrictive admission policies when the result of improper handling of a patient leads to that patient not seeking health care services in the future due to the earlier experience.

ATTACHMENT 27

**Criterion 1110.1540(g)
Charge Commitment**

List of Procedures to be Performed at Proposed ASTC and Accompanying Charges

The following chart provides a list of procedures that will be performed at the proposed ASTC, along with the appropriate CPT/HCPCS code for each procedure and the charge associated with each.

Description of Procedure	Code	Charge
EGD	43235	\$2,900.00
EGD W BIOPSY	43239	\$3,374.74
EGD W REMOVAL OF FOREIGN BODY	43247	\$1,597.38
EGD W SNARE POLYPECTOMY	43251	\$1,597.38
ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP)	43269	\$4,407.06
EXCISION OF ONE OR MORE LESIONS SMALL/LARGE INTESTINES	44110	\$1,597.38
SIGMOIDOSCOPY, FLEXIBLE	45330	\$3,472.50
SIGMOIDOSCOPY W BX	45331	\$3,472.50
COLONOSCOPY	45378	\$3,503.53
COLONOSCOPY W BIOPSY	45380	\$4,505.53
COLONOSCOPY W SNARE POLYPECTOMY	45385	\$6,259.00
SHOULDER CAPSULORRHAPHY	29806	\$12,991.52
REPAIR OF SLAP LESSION SHOULDER	29807	\$12,991.52
SHOULDER DEBRIDEMENT	29823	\$8,172.61
SHOULDER ARTHROSCOPY, DISTAL CLAVICULECTOMY	29824	\$5,497.32
SHOULDER DECOMPRESSION	29826	\$12,991.52
ROTATOR CUFF REPAIR	29827	\$12,991.52
KNEE SYNOVECTOMY	29875	\$6,805.96
KNEE ARTHROSCOPY DEBRIDEMENT/SHAVING OF ARTICULAR CARTILAGE	29877	\$5,497.32
KNEE ARTHROSCOPY W/MENISCECTOMY MEDIAL/LATERAL W SHAVING	29880	\$5,497.32
KNEE MENISCECTOMY	29881	\$8,172.61
MEDIAL OR LATERAL MENISCUS REPAIR	29882	\$8,172.61
MEDIAL AND LATERAL MENISCUS REPAIR	29883	\$12,991.52
LIGAMENT REPAIR W AUGMENTATION/RECONS	29888	\$13,122.73
CARPAL TUNNEL RELEASE	29848	\$7,115.00
CAPSULOTOMY, EACH JOINT	28272	\$5,400.00
TENDON SHEATH INCISION	26055	\$3,102.37

ATTACHMENT 27

Criterion 1110.1540(g) -- Charge Commitment

ARTHROPLASTY, INTERPOSITION, INTERCARPAL/CARPOMETACARPAL JOINTS	25447	\$6,424.15
EXCISION OF GANGLION, WRIST (DORSAL OR VOLAR); PRIMARY	25111	\$3,102.37
LUMBAR LAMINECTOMY, SINGLE SEGMENT	63047	\$16,661.00
LAMINOTOMY W DECOMPRESSION OF NERVE	63030	\$12,732.30
NEUROPLASTY, MEDIAN NERVE AT CARPAL TUN	64721	\$6,096.34
NEUROPLASTY, MAJOR PERIPHERAL NERVE	64712	\$3,371.09
INJECTION MAJOR JOINT	20610	\$2,815.93
CARPAL TUNNEL THERAPEUTIC INJECTION	20526	\$2,305.00
INJECTION, SINGLE/MULTIPLE TRIGGER POINTS, 3 OR MORE MUSCLES	20553	\$3,436.00
INJECTION SINGLE/MULTIPLE TRIGGER POINTS, 1 OR 2 MUSCLES	20552	\$3,436.00
SACROILIAC JOINT INJECTION	27096	\$5,655.00
LUMBAR DISCOGRAM	62290	\$3,692.50
CERVICAL DISCOGRAM	62291	\$3,692.50
EPIDURAL STEROID INJECTION CER OR THORACIC	62310	\$2,843.21
LUMBAR STEROID INJECTION	62311	\$2,843.21
NERVE BLOCK PERIPHERAL	64450	\$1,834.27
FACET JOINT INJECTION, ADD'L LEVEL	64476	\$1,815.93
TRANSFORAMINAL EPIDURAL INJECTION, CERVICAL / THORACIC SPINE	64479	\$1,843.21
TRANSFORAMINAL EPIDURAL INJECTION, CERVICAL / THORACIC SPINE, ADD'L LEVEL	64480	\$1,843.21
TRANSFORAMINAL EPIDURAL INJECTION, LUMBAR / SACRAL SPINE	64483	\$1,843.21
TRANSFORAMINAL EPIDURAL INJECTION, LUMBAR / SACRAL SPINE, ADD'L LEVEL	64484	\$1,843.21
CERVICAL MEDIAL BRANCH BLOCK	64490	\$3,084.00
CERVICAL MEDIAL BRANCH BLOCK ADD LEVEL	64491	\$3,084.00
CERVICAL MEDIAL BRANCH BLOCK ADD LEVEL	64492	\$1,998.00
LUMBAR MEDIAL BRANCH BLOCK ADD LEVEL	64493	\$5,992.00
LUMBAR MEDIAL BRANCH BLOCK ADD LEVEL	64494	\$3,080.00
LUMBAR MEDIAL BRANCH BLOCK ADD LEVEL	64495	\$2,381.00
INJECTION, ANESTHETIC AGENT, STELLATE GANGLION	64510	\$1,834.27
INJECTION, ANESTHETIC AGENT, LUMBAR OR THORACIC	64520	\$1,834.21
INJECTION, ANESTHETIC AGENT, CELIAC PLEXUS	64530	\$1,834.21
VASOVASOSTOMY	55400	\$4,519.12
PROSTATE NEEDLE BX, ANY APPROACH	55700	\$2,061.00
ANKLE ARTHROSCOPY W ARTHRODESIS	29899	\$13,122.73
ANKLE DEBRIDEMENT	29898	\$8,990.00
ANKLE ARTHROSCOPY, REMOVAL OF BODY	29894	\$6,497.03

ATTACHMENT 27

Criterion 1110.1540(g) -- Charge Commitment

198 B

BUNION REMOVAL/CORRECTION	28296	\$8,957.00
HAMMER TOE CORRECTION	28285	\$6,415.00
REPAIR OF RAPTURED ACHILLES TENDON, PRIMARY	27650	\$7,891.19
REPAIR, PRIMARY, OPEN OF ACHILLES TENDON, WITH GRAFT	27652	\$12,786.66
REPAIR OF RAPTURED ACHILLES TENDON, SECONDARY	27654	\$7,891.19
REPAIR OF FLEXON TENDON	27658	\$4,008.19
REPAIR, PRIMARY, DISRUPTED LIGAMENT, ANKLE	27695	\$4,826.13
REPAIR, PRIMARY, DISRUPTED LIGAMENT, ANKLE, BOTH COLLATERAL LIGAMENTS	27696	\$4,826.13
REPAIR, EXTENSOR TENDON, LEG; SECONDARY, WITH OR WOTHOUT GRAFT, EACH TENDON	27665	\$4,826.13
REPAIR, SECONDARY, DISRUPTED LIGAMENT, ANKLE COLLATERAL	27698	\$4,826.13
REMOVAL OF ANKLE IMPLANT	27704	\$4,008.19
ORIF MEDIAL MALLEOLUS FX	27766	\$7,209.20
ORIF DISTAL FIBULAR FX	27792	\$7,209.20
ORIF FIBULAR FX	27814	\$7,209.20
ORIF ANKLE	27822	\$7,209.20
ORIF PORTION OF DISTAL TIBIA, FIBULA ONLY	27826	\$7,209.20
ORIF, PORTION OF DISTAL TIBIA, TIBIA ONLY	27827	\$10,988.54
ORIF, PORTION OF DISTAL TIBIA, BOTH TIBIA AND FIBULA	27828	\$10,988.54
ORIF, DISTAL TIBIOFIBULAR JOINT	27829	\$7,209.20
CLOSED TREATMENT OF ANKLE DISLOCATION	27842	\$2,802.91
OPEN TREATMENT OF ANKLE DISLOCATION, WITHOUT REPAIR	27846	\$7,209.20
OPEN TREATMENT OF ANKLE DISLOCATION, WITH REPAIR	27848	\$7,209.20
SESAMOIDECTOMY	28315	\$3,922.86
LESION EXCISION WITH SKIN TAGS 4CM +	11426	\$6,302.00
LESION EXCISION 3.1 CM - 4CM	11424	\$2,900.41
LESION EXCISION (NO SKIN TAGS) 4CM +	11406	\$4,355.46
EXCISION OF CYST	19120	\$3,891.93
SUTURE, RAPTURED MUSCLE	27385	\$4,213.28
APPENDECTOMY, LAPARASCOPY, SURGICAL	44970	\$8,363.53
INCISION OF THROMBOSED HEMORRHOID, EXTERNAL	46083	\$1,597.38
HEMORRHOIDECTOMY, EXTERNAL	46250	\$4,276.60
HEMORRHOIDECTOMY, INTERNAL AND EXTERNAL, SINGLE	46255	\$4,276.60
HEMORRHOIDECTOMY W FISSURECTOMY	46257	\$4,276.60
HEMORRHOIDECTOMY, INTERNAL AND EXTERNAL, 2 OR MORE	46260	\$4,276.60
LAPARASCOPIC CHOLECYSTECTOMY	47562	\$8,791.47

ATTACHMENT 27

Criterion 1110.1540(g) -- Charge Commitment

198C

REPAIR OF UMBILICAL HERNIA	49587	\$5,625.00
REPAIR OF INGUINAL HERNIA	49505	\$8,426.37
REPAIR OF RECURRENT INGUINAL HERNIA	49520	\$8,426.37
REPAIR OF FEMORAL HERNIA	49550	\$5,611.34
REPAIR OF VENTRAL HERNIA	49561	\$5,611.34
LAPAROSCOPIC HYSTERECTOMY	58541	\$8,363.53
TUBAL LIGATION	58600	\$5,475.24
FIBROID REMOVAL	58145	\$5,475.24
SALPINGO-OOPHORECTOMY	58720	\$2,498.27
LAPARASCOPY, LYSIS OF ADHESIONS	58660	\$8,363.53
LAPARASCOPY, SURGICAL, REMOVAL OF ADNEXAL STRUCTURES	58661	\$8,363.53
LAPARASCOPY, SURGICAL, FULGURATION / EXCISION OF LESION, OVARY	58662	\$8,363.53
ENDOMETRIAL ABLATION, THERMAL	58353	\$5,475.24
LAPARATOMY, EXPLORATORY CELIOTOMY W / WO BX	49000	\$2,209.05
EXCISION OR DESTRUCTION INTRA-ABD TUMORS, CYSTS, ENDOMETRIOMA	49203	\$3,065.06
LAPARASCOPY, SURGICAL W BX	49321	\$6,169.42
LAPARASCOPY, SURGICAL WITH ASPIRATION OF CAVITY OR CYST	49322	\$6,169.42
LAPARASCOPY, SURGICAL, WITH DRAINAGE OF LYMPHOCELE	49323	\$6,169.42

Owner's Certification

A letter from Naser Rustom, M.D., the Sole Member of Preferred SurgiCenter, LLC (the "Applicant"), which certifies the Applicant's commitment to maintain the above charges for the proposed ASTCs first two (2) years of operation is attached immediately following this page.

Preferred SurgiCenter
10 Orland Square Drive
Orland Park, Illinois 60462

July 8, 2013

Illinois Health Facilities and Services Review Board
Illinois Department of Public Health
525 West Jefferson St., 2nd Floor
Springfield IL 62761
Attention: Mr. Dale Galassie, Board Chairman

Dear Chairman Galassie:

Pursuant to 77 Ill. Adm. Code § 1110.1540(g), I hereby commit that the attached charge schedule will not be increased, at a minimum, for the first two (2) years of operation following the establishment and opening of Preferred SurgiCenter in Orland Park, Illinois. I further certify that if I wish to alter the attached charge schedule, a certificate of need permit will first need to be obtained pursuant to 77 Ill. Adm. Code § 1110.310(a).

Respectfully Submitted,



Naser Rustom, M.D.
Sole Member
Preferred SurgiCenter, LLC

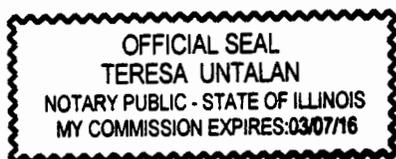
NOTARY:

Subscribed and sworn to me this 10th day of July, 2013



Notary Public

Seal:



Citi Commercial Bank
444 North Main Street
Glen Ellyn, Illinois 60137



June 20, 2013

Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761
Attention: Chairman Galassie

Re: Escrow Agreement

Dear Chairman Galassie:

By this letter, I hereby certify that an account (the "Account") has been opened by Preferred SurgiCenter, LLC (the "Account Holder") at this bank, specifically, the Citibank branch located at 444 North Main Street, Glen Ellyn, Illinois 60137 (the "Bank"). The Account was opened on June 20, 2013 and has been assigned the following account number: 801172695. The Account presently has an available balance of \$3,770,000.00 (the "Account Balance").

Please be advised that the Account Balance has been set aside in escrow to support project costs related to a proposed surgery center that will be located at 10 Orland Square Drive, Orland Park, Illinois 60462 (the "Project"). The Account Balance that will be held in escrow represents an amount that is sufficient to cover the Project's costs as provided by the Account Holder in its certificate of need ("CON") permit application, as amended. A chart showing the Project's total costs, as amended, is attached hereto as Exhibit A.

The Account Holder and the Bank have agreed that withdrawals from the Account will be allowed only after the Illinois Health Facilities and Services Review Board (the "State Board") has either: (1) voted to not grant a CON permit to the Account Holder for the Project, at which time all funds in the Account shall be made available to the Account Holder immediately, or (2) granted a CON permit to the Account Holder for the Project. If the State Board does grant a CON permit for the Project, the Account Balance funds will be dedicated solely to the Project and will be made available to the Account Holder only for covering costs related to or in furtherance of the Project. These funds may be drawn by the Account Holder upon presentation of a written declaration to the Bank that is officially signed by a person authorized by the Account Holder to make such withdrawals from the Account, which declares that the withdrawal is being made pursuant to the terms of the CON permit granted by the State Board. Notwithstanding the foregoing, so long as the Account is in existence, interest that accrues from the Account Balance, if any, shall be payable to the Account Holder without restriction. Once the Account Holder has completed all of the improvements related to the Project and has submitted to the State Board a final realized cost report in conformance with

Citi Commercial Bank
444 North Main Street
Glen Ellyn, Illinois 60137



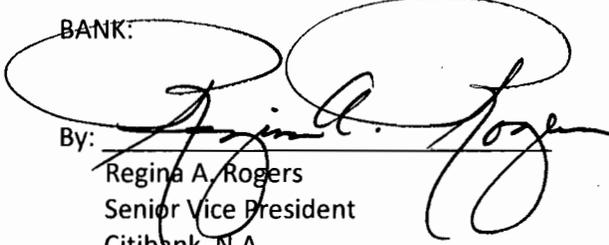
the State Board's requirements and has provided the Bank with a copy of the same, the Bank will remove all restrictions on the Account and make all remaining funds, if any, available to the Account Holder.

The Account Holder, by joining this letter, hereby authorizes the Bank to follow the terms set forth herein and to disburse funds from the Account accordingly.

Sincerely,

BANK:

By:


Regina A. Rogers
Senior Vice President
Citibank, N.A.
Commercial Banking Group

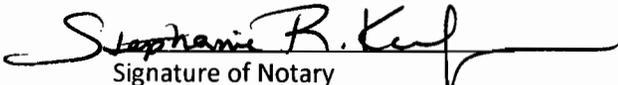
ACCOUNT HOLDER:

By:


Naser Rustom, M.D.
Sole Member
Preferred SurgiCenter, LLC

Notarization:

Subscribed and sworn before me this
20th day of June

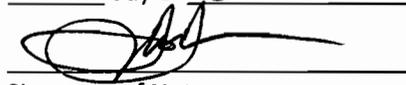

Signature of Notary

Seal



Notarization:

Subscribed and sworn before me this
20th day of June


Signature of Notary

Seal



202 B

Exhibit A

Project Costs & Sources of Funds (Amended)

Preferred SurgiCenter, LLC
CON Project 13-007

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs	\$20,000	\$10,000	\$30,000
Site Survey and Soil Investigation	\$0	\$0	\$0
Site Preparation	\$50,000	\$15,000	\$65,000
Off Site Work	\$0	\$0	\$0
New Construction Contracts	\$0	\$0	\$0
Modernization Contracts	\$1,450,000	\$250,000	\$1,700,000
Contingencies	\$80,000	\$20,000	\$100,000
Architectural/Engineering Fees	\$150,000	\$30,000	\$180,000
Consulting and Other Fees	\$15,000	\$5,000	\$20,000
Movable or Other Equipment (not in construction contracts)	\$925,000	\$75,000	\$1,000,000
Bond Issuance Expense (project related)	\$0	\$0	\$0
Net Interest Expense During Construction (project related)	\$0	\$0	\$0
Fair Market Value of Leased Space or Equipment	\$550,000	\$125,000	\$675,000
Other Costs To Be Capitalized	\$0	\$0	\$0
Acquisition of Building/Other Property (excluding land)	\$0	\$0	\$0
TOTAL USES OF FUNDS	\$3,190,000	\$580,000	\$3,770,000
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	\$3,190,000	\$580,000	\$3,770,000
Pledges	\$0	\$0	\$0
Gifts and Bequests	\$0	\$0	\$0
Bond Issues (project related)	\$0	\$0	\$0
Mortgages	\$0	\$0	\$0
Leases (fair market value)	\$0	\$0	\$0
Governmental Appropriations	\$0	\$0	\$0
Grants	\$0	\$0	\$0
Other Funds and Sources	\$0	\$0	\$0
TOTAL SOURCES OF FUNDS	\$3,190,000	\$580,000	\$3,770,000

ATTACHMENT 42

**Criterion 1120.140
Economic Feasibility**

A. Reasonableness of Financing Arrangements

A signed and notarized statement from Preferred SurgiCenter, LLC (the "Applicant") is attached immediately following this attachment. The statement attests that the project is being funded entirely by available cash and that no financing will be secured to pay for the development of the proposed surgery center.

B. Conditions of Debt Financing

The only debt in this project results from an eventual lease that will be entered into between the site owner and the Applicant. The following documents are attached immediately following this attachment:

1. A copy of the executed Letter of Intent to Lease, which upon permit issuance, will be replaced by a formal lease agreement between the two parties as soon as said parties agree to the final terms for the lease agreement.
2. A signed and notarized statement from the Applicant, which certifies that the project involves the leasing of a health care facility, and that expenses related to the lease are less costly than constructing a new facility.

C. Reasonableness of Project and Related Costs

The following chart identifies the department impacted by the proposed project (the entire ASTC as proposed) and provides a cost and square footage allocation related to this modernization project.

Cost and Gross Square Feet By Department or Service									
Department (list Below)	A	B	C	D	E	F	G	H	Total cost (G+H)
	Cost/Square Foot new Mod.		Gross Sq Ft New Circ.*		Gross Sq Ft Mod. Circ.*		Const. \$ (AXC)	Mod. \$ (BXE)	
ASTC (Clinical)		\$200.00			8,800	0%		\$1,760,000	\$1,760,000
Contingency		\$25.00			8,800	0%		\$220,000	\$220,000
TOTAL		\$225.00			8,800	0%		\$1,980,000	\$1,980,000

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

Year 2015

Operating Expenses: \$1,636,085

Procedures: 6,383

Operating Expense/Procedure: \$256.32

E. Total Effect of the Project on Capital Costs

Year 2015

Capital Costs: \$161,750

Procedures: 6,383

Capital Costs/Procedure: \$25.34

Preferred SurgiCenter
10 Orland Square Drive
Orland Park, Illinois 60462

July 8, 2013

Illinois Health Facilities and Services Review Board
Illinois Department of Public Health
525 West Jefferson St., 2nd Floor
Springfield IL 62761
Attention: Mr. Dale Galassie, Board Chairman

Re: Reasonableness of Project and Related Costs

Dear Chairman Galassie:

Preferred SurgiCenter, LLC (the "Applicant") is paying for the development of an ambulatory surgical treatment center in Orland Park, Illinois (the "Project") with available cash and other internal resources and is not borrowing any funds for the Project. However, pursuant to the rules of the Illinois Health Facilities and Services Review Board (the "State Board"), the entering of a lease agreement is treated as tantamount to borrowing. As a result, I, the undersigned, hereby attest that the entering into of a lease is less costly than the liquidation of existing investments which would be required to buy the property from the current site owner and pursue the Project alone. Furthermore, should the site owner require the Applicant to pay off the lease in full, the Applicant's existing investments and available capital could be converted to cash or used to retire the outstanding lease obligations within a sixty (60) day period.

Respectfully Submitted,



Naser Rustom, M.D.
Sole Member
Preferred SurgiCenter, LLC

NOTARY:

Subscribed and sworn to me this 10th day of July, 2013



Notary Public

Seal:



ATTACHMENT 42

Criterion 1120.140 -- Economic Feasibility

207

ATTACHMENT 43

Safety Net Impact Statement

I. Overview

Pursuant to the Illinois Health Facilities Planning Act, 20 ILCS 3960/5.4 (the "Act"), any application related to a "substantive" project must include a Safety Net Impact Statement ("Statement"). The Applicant is proposing the establishment of a health care facility, which according to the Act, classifies the proposed ambulatory surgical treatment center ("ASTC") as a substantive project. As a result, the Applicant submits this Statement as required by the Act.

II. Analysis

Section 5.4(c) of the Act provides that each CON applicant presenting a substantive application must include a Statement with its application for permit. The Statement must describe all of the following: (i) the project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge, (ii) the project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant and (iii) how the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant. Each of these elements of the required Statement are discussed below.

1. Impact on Essential Safety Net Services in the Community

Section 5.4(c)(1) of the Act requires an applicant to address whether the project will have a material impact on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge. For the following reasons, the Applicant firmly believes that the proposed Project will not have an adverse impact on essential safety net services in the community.

First, the proposed ASTC will improve the safety net services available in the Applicant's defined geographic service area ("GSA"), which is a forty-five (45) minute drive time radius around the project's site in Orland Park, Illinois. The federal Health Resources and Services Administration ("HRSA"), a subsidiary agency of the U.S. Department of Health and Human Services, identifies a number of geographic areas in the proposed GSA that are medically underserved areas and/or medically underserved populations ("MUA/Ps"). MUAs may be a whole county or a group of contiguous counties, a group of county or civil divisions or a group of urban census tracts in which residents are identified to have a shortage of personal health services. MUPs may include groups of persons who face economic, cultural or linguistic barriers to health care.

In Cook County, the southern and southwest suburbs have a large number of areas designated as either MUAs or MUPs. For example, MUA/Ps are identified in Robbins, Harvey, Chicago Heights, Riverdale, Summit, Kenwood, Blue Island, and Calumet City, Illinois. All of these communities will be in close proximity to the proposed ASTC. In addition, a significant number

of zip code areas on the south and southwest sides of the City of Chicago have also been designated as MUA/P's. See the attached print out from the HRSA website, which identifies all of the areas identified above.

Second, the proposed ASTC will enhance the health care services in its GSA because the surgery center will provide culturally-sensitive services to Arab and Arab and Muslim Americans. Studies have shown that this demographic group are typically underserved, a fact that is quite troubling when HRSA has already identified many of the local communities or parts thereof as MUA/Ps.

Third, the proposed ASTC will be an enrolled Medicaid provider and also offer a charity care program for individuals who have a demonstrated need for free or reduced cost care.

2. Impact on the Ability of Other Providers or Health Care Systems to Cross-Subsidize Safety Net Services.

Section 5.4(c)(2) of the Act adds that an applicant must discuss the project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant. Under this section, cross subsidization is understood to mean the practice of charging higher prices to one group of consumers in order to subsidize lower prices for another group (i.e., cost shifting to paying populations to offset losses incurred from assistance programs like charity care).

As noted above, the ASTC will accept Medicaid patients and offer a charity care program to persons who are uninsured or unable to pay. As a result, this ASTC will provide a net positive effect on the community as a whole, which will result in a stronger safety net in the area that the Applicant will serve.

Moreover, the Applicant knows of no reason why the proposed ASTC would impair the ability of other providers or health care systems to cross-subsidize any safety net services they may provide.

3. No Discontinuation of Safety Net Services

Section 5.4(c)(3) of the Act provides that an applicant must describe how the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant. This permit request is for the establishment of a new health care facility, not a discontinuation; therefore, this part of the Statement is not applicable to the project.

4. Additional Safety Net Impact Statement Information

The Act also declares that the Statement shall include all of the following:

- (i) for the three (3) fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant (the amount calculated by

hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act; non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the HFSRB),

(ii) for the three (3) fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients (hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payer Source" and "Inpatient and Outpatient Net Revenue by Payer Source" as required by the HFSRB under Section 13 of the Act and published in the Annual Hospital Profile), and

(iii) information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

In satisfaction of this requirement, please find attached to this Statement a certified letter that attest to the foregoing and provides additional information the Applicant believes is directly relevant to safety net services for individuals who are Arab and Arab and Muslim Americans.

(a) Charity Care & Medicaid Tables

The Applicant is a newly-formed entity and is not an established provider. Consequently, the Applicant cannot provide historical data as it pertains to charity care and Medicaid services. Nevertheless, the Applicant will be establishing a charity care program once the ASTC becomes operational and financially viable and will also enroll as a provider in the Medicaid program.

CHARITY CARE			
	Year 2011	Year 2012	Year 2013
Net Patient Revenue	\$0	\$0	\$0
Amount of Charity Care	\$0	\$0	\$0
Cost of Charity Care	\$0	\$0	\$0

MEDICAID			
Medicaid (# of patients)	Year 2011	Year 2012	Year 2013
ASTC	0	0	0
Total	0	0	0
Medicaid (revenue)			
Total	\$0	\$0	\$0

However, as noted above, the Applicant plans to enroll in Medicaid and offer charity care to needy patients. The following chart provides an estimate of payer mix during the first two years of operation after the ASTC becomes operational. The first year anticipates a lower amount of Medicaid and charity care as the community will need to learn of these services at the ASTC.

FORECASTED PAYER MIX			
	Year 2014	Year 2015	Year 2016
Private Insurance	0.0%	86.0%	74.0%
Medicare	0.0%	5.0%	11.0%
Medicaid	0.0%	5.0%	10.0%
Self Pay	0.0%	2.0%	2.0%
Charity Care	0.0%	2.0%	3.0%
TOTAL	100.0%	100.0%	100.0%

Although the Applicant is committed to participating in Medicaid, and fully intends to offer a charity care program, the numbers provided above are nothing more than estimates based on similarly-situated ASTCs. The forecast does not take into account the unknown effect that full implementation of Obamacare will have on the delivery and payment of health care services in the United States.

Preferred SurgiCenter
10 Orland Square Drive
Orland Park, Illinois 60462

July 8, 2013

Illinois Health Facilities and Services Review Board
Illinois Department of Public Health
525 West Jefferson St., 2nd Floor
Springfield IL 62761
Attention: Mr. Dale Galassie, Board Chairman

Re: Safety Net Impact Statement Certification

Dear Chairman Galassie:

Preferred SurgiCenter, LLC (the "Applicant") is a newly formed business entity created solely for the purpose of owning and operating the ambulatory surgical treatment center ("ASTC") to be located at 10 Orland Square Drive, Orland Park, Illinois 60462. Based on this fact, the Applicant is unable to provide the historical Medicaid and charity care data as requested in the certificate of need permit application.

However, the Applicant commits to becoming an enrolled Medicaid provider, and also intends to implement a charity care program once the ASTC becomes operational and financially viable. As a result, the proposed ASTC will enhance the safety net services available in the proposed geographic service area.

Finally, the ASTC will enhance safety net services because the Applicant's goal is to serve a recognized population group with a history of lacking adequate access to health care services.

Respectfully Submitted,



Naser Rustom, M.D.
Sole Member
Preferred SurgiCenter, LLC

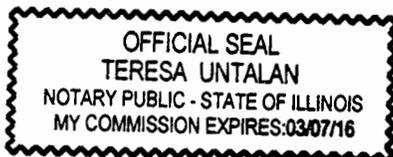
NOTARY:

Subscribed and sworn to me this 10th day of July, 2013



Notary Public

Seal:



217

ATTACHMENT 43
Safety Net Impact Statement

ATTACHMENT 44

Charity Care and Medicaid Participation

Pursuant to the Illinois Health Facilities Planning Act, "charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer (20 ILCS 3960/3). Charity care must be provided at cost. All applicants and co-applicants are required to indicate the amount of charity care provided for the latest three audited fiscal years, the cost of such charity care and the ratio of that charity care cost to net patient revenue. *If an applicant is not an existing facility, the applicant is required to submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.*

Based on the foregoing requirements as applied to a newly-formed entity, please note the following:

Preferred SurgiCenter, LLC (the "Applicant") is a new business entity formed for the sole purpose of owning and operating the proposed ASTC. Consequently, the Applicant cannot provide historical data as it pertains to charity care. Nevertheless, the Applicant will be establishing a charity care program once the ASTC becomes operational and is financially viable.

CHARITY CARE			
	Year 2011	Year 2012	Year 2013
Net Patient Revenue	\$0	\$0	\$0
Amount of Charity Care	\$0	\$0	\$0
Cost of Charity Care	\$0	\$0	\$0

However, as noted above, the Applicant plans to enroll in Medicaid and offer charity care to needy patients. The following chart provides an estimate of payer mix during the first two years of operation after the ASTC becomes operational. The first year anticipates a lower amount of Medicaid and charity care as the community will need to learn of these services at the ASTC.

FORECASTED PAYER MIX			
	Year 2014	Year 2015	Year 2016
Private Insurance	0.0%	86.0%	74.0%
Medicare	0.0%	5.0%	11.0%
Medicaid	0.0%	5.0%	10.0%
Self Pay	0.0%	2.0%	2.0%
Charity Care	0.0%	2.0%	3.0%
TOTAL	100.0%	100.0%	100.0%

Although the Applicant is committed to participating in Medicaid, and fully intends to offer a charity care program, the numbers provided above are noting more than estimates based on similarly-situated ASTCs. The forecast does not take into account the unknown effect that full implementation of Obamacare will have on the delivery and payment of health care services in the United States.

Please find attached a draft charity care policy and application form.

Pages 231 through 242 of the original CON permit application are deleted.

Refer to pages 182 through 194-W of the amended CON permit application for the most current physician referral letters.

AFFILIATED SURGICARE, LTD.

4941 NORTH KEDZIE AVENUE
CHICAGO, IL 60625-5009

CITIBANK, N.A. BR. #12

CHICAGO, IL 60623
2-7080-2710

7/10/2013

PAY TO THE ORDER OF ILLINOIS DEPARTMENT OF PUBLIC HEALTH

\$ ****2,000.00**

Two Thousand and 00/100***** DOLLARS

ILLINOIS DEPARTMENT OF PUBLIC HEALTH



AUTHORIZED SIGNATURE

MEMO PROJECT # 13-007 *Preferred Surgicenter, LLC*

⑈001328⑈ ⑆27107080⑆ ⑆0800514894⑈

AFFILIATED SURGICARE, LTD.

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

7/10/2013

2,000.00

RECEIVED

JUL 15 2013

HEALTH FACILITIES &
SERVICES REVIEW BOARD

CITIBANK CHECKIN PROJECT # 13-007

2,000.00

Security features. Details on back.