

Interfaith Spiritual Care in Shariah-Compliant Healthcare: Patient Experiences from Malaysia

Nurasikin Mohamad Shariff^{1*}, Lee Siew Pien¹, Norfadzilah Ahmad²

ABSTRACT

OBJECTIVE: To explore the experiences and perspectives of non-Muslim patients receiving spiritual care from Muslim-trained providers in a Shariah-compliant tertiary hospital.

METHODOLOGY: A qualitative, exploratory design was employed, using non-participant observation and informal interviews with 16 non-Muslim patients from Buddhist, Christian, Hindu, Orang Asli, and atheist backgrounds. Each participant received an individual spiritual care session conducted by a Muslim provider in the ward. Data were analyzed thematically following Braun and Clarke's six-phase approach to identify recurring patterns and meanings across participants.

RESULTS: Two main themes emerged. The first, *Values Over Rituals*, revealed that patients valued compassion, sincerity, and respect more than ritualistic or faith-specific practices. The second, *Positive Reception Across Beliefs*, reflected patients' appreciation of the providers' presence and goodwill, even when religious traditions differed. Participants described the encounters as comforting and inclusive, though some refrained from critique due to perceived appropriateness of the service within an Islamic institution.

CONCLUSION: Non-Muslim patients valued spiritual care grounded in universal human values and relational presence rather than doctrinal alignment. The findings not only inform the development of inclusive, patient-led approaches in Shariah-compliant healthcare but also enrich the global interfaith discourse by highlighting how compassion and respect can transcend religious boundaries in plural healthcare environments.

KEYWORDS: Chaplaincy, Cultural Sensitivity, Interfaith Spiritual Care, Non-Muslim Patients, Shariah-Compliant Hospital

INTRODUCTION

Healthcare in Malaysia's plural societies is increasingly characterized by religious and cultural diversity. Patients admitted to hospitals bring with them a broad spectrum of worldviews, ranging from deeply religious commitments to secular or non-religious orientations. This diversity creates both opportunities and challenges for spiritual care, especially when it is not widely recognized within Malaysian healthcare services. In contrast, there is a global interest in interfaith spiritual care (ISC), defined as the provision of spiritual support when the caregiver and patient belong to different religious or non-religious backgrounds^{1,2}.

The worldwide landscape of spiritual care, or chaplaincy, begins with Christian traditions from Western countries. Later, it expands to include Jewish, Muslim, Buddhist, and interfaith models³. The criticism, however, relies heavily on Western

assumptions about faith, neutrality, and professional identity. Studies suggest that while presence, reflective communication, and narrative engagement are universally recognized as core practices^{4,5}, tensions arise around authenticity and cultural appropriateness when chaplains engage across traditions^{6,7}. It is argued that mismatches between provider and patient backgrounds can complicate care encounters⁸. Emerging literature suggests a shift from ritual-based models of care toward more relational and values-based approaches. Protestant and humanist traditions are often associated with counselling and narrative support, whereas Catholic, Orthodox, Hindu, and Muslim traditions tend to draw on ritual, legal, and ethical frameworks^{8,9}. In clinical practice, however, many patients do not identify strongly with ritual or doctrinal language; instead, they frequently seek presence, compassion, and family support as fundamental dimensions of spiritual care, particularly during illness, suffering, and end-of-life moments⁹. Studies in Japan, for example, found that patients welcomed chaplains from diverse religious backgrounds provided they embodied compassion and refrained from proselytisation¹⁰.

In multicultural societies nowadays, ISC offers opportunities for dialogue and mutual learning. Patients may at times feel freer to speak openly with caregivers of a different faith, mainly when taboos or cultural norms constrain conversations within their

¹Department of Special Care Nursing, International Islamic University Malaysia, Jalan Sultan Ahmad Shah, 25200 Indera Mahkota, Kuantan, Pahang, Malaysia.

²Department of Professional Nursing Studies, International Islamic University Malaysia, Jalan Sultan Ahmad Shah, 25200 Indera Mahkota, Kuantan, Pahang, Malaysia.

Correspondence: nurasikin@iiu.edu.my
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own tradition². Spiritual scholars acknowledge that barriers remain: language differences, institutional constraints, and the lingering dominance of Western-Christian models continue to limit inclusivity^{11,12}. These realities highlight the urgent need for culturally adapted models of spiritual care that resonate with local populations. The ASEAN region exemplifies these challenges and opportunities for offering ISC, though at the beginning of spiritual services with limited training in hospital-based chaplaincy. Countries such as Malaysia, Singapore, Indonesia, and the Philippines are characterized by deep pluralism, in which Islam, Christianity, Buddhism, Hinduism, and indigenous traditions coexist. Healthcare institutions reflect these dynamics, serving multi-faith populations within national frameworks often shaped by a dominant religious ethos. In Singapore, secular healthcare policies have restricted overt religious practices, while in Indonesia and the Philippines, Christian models of chaplaincy have historically dominated. In Malaysia, spiritual care within Shariah-compliant hospitals is guided by Islamic principles but must also meet the needs of Buddhist, Hindu, Christian, and non-religious patients^{13,14}.

Although there is growing acknowledgement of ISC as an ethical necessity in such plural contexts, practical guidance remains scarce. Most evidence on ISC has centred on conceptual frameworks or chaplains' perspectives, with little attention to how patients themselves experience care delivered across religious differences. This gap is significant because patient perspectives are essential for designing models that are not only theoretically sound but also experientially relevant. These insights resonate strongly with the Malaysian context, where generational shifts, interfaith families, and secularisation have produced diverse orientations among patients. Younger generations of Orang Asli, for instance, may have little connection to ancestral rituals, while urban Buddhists or Hindus may mix cultural practices with secular worldviews. Recognizing this plurality is critical if spiritual care is to remain patient-centred and culturally sensitive.

Shariah-compliant hospitals in Malaysia are guided by Islamic ethics that integrate Shariah principles into governance, clinical practice, and patient experience¹⁴. It operates within an Islamic ethical framework but serves patients of multiple faiths or none. While Muslim patients may receive care aligned with their beliefs, little is known about how non-Muslim patients experience spiritual care in these settings. More importantly, no prior study has examined non-Muslim patients' lived experiences within an Islamic hospital framework in Southeast Asia. This is a significant gap, as the hospital's ethos could be perceived as limiting or excluding non-Muslims, potentially affecting inclusivity and trust. Therefore, this study aims to explore the experiences and perspectives of non-Muslim patients receiving spiritual care in a Shariah-compliant Malaysian hospital, focusing on what they found most meaningful in their

encounters with spiritual care providers.

METHODOLOGY

Study Design and Setting

This study employed a qualitative exploratory design to capture the experiences of non-Muslim patients after receiving spiritual care from Muslim chaplains. The study was conducted in a Shariah-compliant tertiary hospital in Pahang, Malaysia. The hospital operates within an Islamic ethical framework but admits patients of multiple faiths or no religious affiliation. Spiritual care services were provided by the Department of Shariah Compliance, comprising trained Muslim providers who had undergone internal hospital training and external Clinical Pastoral Education (CPE).

Study Sample

Sixteen participants, representing Buddhist, Christian, Hindu, Orang Asli, and atheist backgrounds, were recruited from medical, surgical, and orthopaedic wards. Recruitment was based on nurses' recommendations, in accordance with predefined inclusion and exclusion criteria. Inclusion criteria were: (1) non-Muslim patients (or relatives), and (2) ability to communicate experiences in Malay or English. Patients who were critically unstable or unable to communicate meaningfully were excluded.

Instrument and data collection

Data were gathered between March and May 2025 through non-participant observations and informal interviews. Non-participant observations typically lasted 20-30 minutes per encounter, encompassing 16 spiritual care sessions delivered by six providers. Observations focused on provider-patient interactions and were guided by the six core competencies of spiritual nursing care¹⁵. The observations were recorded by the same observer using a yes/no checklist, with additional notes written in the remarks column.

Following each observation, informal interviews were conducted with patients or relatives to explore their perspectives on the encounter. Interviews were not audio-recorded; notes were taken in real time. Audio recording was not feasible due to ward privacy restrictions and participants' preference for conversational encounters rather than formal interviews. Fieldnotes were written by hand in the ward immediately after each interview, before the researcher left the setting, to ensure accuracy and completeness of recall. Steps in the note-taking procedure are as follows:

1. Real-time jotting: Key points and short verbatim phrases were noted discreetly during each conversation.
2. Immediate elaboration: Notes were expanded into detailed fieldnotes immediately after each encounter, while the context and expressions were still fresh.
3. Validation with participants: At the end of each encounter, key points were briefly summarised to

participants to confirm accuracy and clarify meaning.

Data Analysis

Data were analyzed using Braun and Clarke's six-phase thematic analysis. Initial codes were generated inductively, grouped into categories, and refined into themes, with emphasis placed on capturing patients' voices. The competency checklist¹⁵ was applied to support the evaluation of providers' practices. It was not used as a coding framework; instead, it served a confirmatory role, validating themes inductively derived from participants' accounts.

Data was organized and coded manually using colour coding. Thematic saturation was considered achieved when no new codes or categories emerged after repeated analysis of observations and interviews across participants from different backgrounds. Although each faith group was represented by only of few participants, the recurrence of similar patterns across heterogeneous cases indicated adequate thematic saturation.

Ethical Statement

Ethical approval was granted by the IIUM Research Ethics Committee (IREC:2024-349). Written informed consent was obtained from both patients and spiritual care providers before observation and interviews. Participants were assured of anonymity and voluntary participation. Fieldnotes and checklists were securely stored in password-protected digital files, while handwritten notes were anonymized and kept in a locked cabinet accessible only to the research team. Anonymity was maintained through the use of pseudonyms and the removal of identifying details in reporting.

To ensure rigour, several strategies were employed: (1) triangulation of data sources (observations and interviews); (2) dependability, through collaborative coding and consensus among multiple researchers; (3) confirmability, by maintaining reflexive notes documenting assumptions and analytic decisions; and (4) transferability, supported by rich contextual descriptions of participants and encounters.

As all providers were Muslim-trained, patients' responses may have been shaped by respect for religious authority, which could influence openness. Reflexive notes were kept to mitigate this.

RESULTS

Profile of Spiritual Care Providers

A total of six Muslim spiritual care providers (SC1–SC6) were involved, with professional experience ranging from 1.5 to 5 years. Two providers were female, and four were male.

Patient Characteristics

Spiritual care was provided to 16 participants across medical, surgical, and orthopaedic wards. Patients represented diverse religious and non-religious backgrounds, including Buddhism, Christianity, Hinduism, Orang Asli traditions, and atheism. Ages ranged from 26 to 80 years, with equal representation

of males and females. Hospital stays ranged from 1 to 28 days.

Thematic Findings

Two overarching themes were identified:

1. Values Over Rituals

Patient accounts, observational data, and competency assessments supported these themes.

Theme 1: Values Over Rituals

Participants frequently described spirituality in terms of kindness, sincerity, and moral values rather than formal religious practice. Spiritual care was perceived as meaningful when rooted in compassion and interpersonal respect.

"You don't need to ask about religious practice; it is enough to have a good heart." (Buddhist, female, 73-year-old patient)

"I think being sincere is more important than following rituals that I don't understand." (Orang Asli, male, 26-year-old patient)

"What matters is whether the care comes from a place of compassion, not whether it matches my religion." (Christian, female, 52-year-old patient)

These accounts highlight that patients valued genuine human connection over doctrinal alignment.

Theme 2: Positive Reception Across Beliefs

Most participants expressed appreciation for the providers' presence, goodwill, and respectful approach, even when religious practices differed.

"I'm happy when they pray for me, even if I do not practice religion." (Atheist, female, 64-year-old patient)

"It's touching to know they want to pray for my recovery, even if it's in their own way." (Hindu, male, 40-year-old patient)

"They showed respect for me as a person first. That's what matters most." (Buddhist, female, 45-year-old)

"I felt included, not left out, even though my beliefs are different." (Christian, male, 70-year-old)

This sense of acceptance fostered comfort and reduced concerns about exclusion in a Shariah-compliant hospital.

Competency Evaluation of ISC Sessions (n=16)

Competency evaluation was conducted across 16 observed sessions (n = 16) using the hospital's spiritual care competency checklist. Percentages were calculated based on the total number of sessions in which each competency was demonstrated. The report revealed strengths in neutrality, empathy, and respect for patient preferences, while highlighting gaps in language use, intervention planning, and family involvement.

- Ability to handle own beliefs: Providers demonstrated strong neutrality (16/16; 100%) and generally avoided imposing personal beliefs (15/16; 93.75%). Patients confirmed feeling no pressure, though occasional lapses occurred when religious practices were suggested without patient initiation.
- Ability to collect spiritual information: Providers

consistently asked about beliefs (100%), but some patients had limited religious literacy, leading to superficial responses. Language was sometimes overly formal, with patients preferring simpler questions.

- Ability to address the spirituality of patients: Providers showed empathy and sensitivity (93.75%) and offered supportive presence through verbal and non-verbal communication.
- Discuss spiritual planning and intervention with patients: Family involvement (if needed) occurred in just over half of cases (9/16; 56.25%), while interventions aligned with patient beliefs were proposed in fewer than half (7/16; 43.75%). Patients often declined ritual-based care, emphasizing respect for their autonomy.
- Provide and evaluate spiritual care: Respect for preferences was universal (100%), and providers generally reviewed feedback effectively (93.75%). Patients commonly described visits as “a nice effort” or “good enough.”

Triangulated Interpretation

Triangulation of observations and patient feedback confirmed that the core strength of spiritual care lay in empathetic presence, respect, and neutrality. The main gap was translating assessments into tailored interventions, particularly for patients with low religious literacy or non-religious identities.

DISCUSSION

The findings reveal that non-Muslim patients experienced spiritual care as affirming universal human values, welcoming inclusion, and enabling diverse meaning-making within a faith-informed hospital. Compassion and presence were consistently prioritized over ritual practices, reflecting international literature that highlights relational presence as more meaningful than faith concordance^{2,4,9}. Patients valued dignity, sincerity, and being listened to, underscoring that effective spiritual care is rooted in human connection rather than religious concordance. By centring the voices of non-Muslim patients, this study contributes novel insights into interfaith spiritual care (ISC) in Malaysia. Their positive reception demonstrates that interfaith encounters can be embraced when anchored in respect and inclusivity. At the same time, secular or cultural pathways of spirituality highlight the importance of recognizing meaning-making beyond formal religion. These findings affirm Ganzevoort’s (2016) call for a universal approach grounded in shared values and flexible models⁹.

Importantly, patients did not resist receiving care from Muslim providers; instead, they contextualized the encounters within their own frameworks of belief. This aligns with prior studies indicating that faith concordance is less significant than the quality of relational presence^{2,10}. In this context, simple gestures—such as asking about concerns—were

deeply valued, illustrating that non-Muslim patients were not alienated but grateful for inclusion.

At the same time, the findings highlight the limitations of Western chaplaincy models that often privilege ritual fidelity or Christian-centric assumptions⁷⁻⁸. While ritual-based care may be central in some traditions, the patients in this study preferred relational and compassionate support. This suggests that chaplaincy training in multicultural contexts should emphasize moral presence, reflective dialogue, and interfaith sensitivity as universal practices.

Beyond Malaysia, the findings also hold relevance for neighbouring ASEAN countries with distinct religious dynamics. In Singapore, where healthcare systems are strongly secular, the emphasis on compassion and presence over ritual is consistent with policies aimed at ensuring inclusivity without privileging any tradition. In the Philippines, where Christian chaplaincy is predominant, the findings underscore the need to accommodate plural expressions of spirituality, especially for non-Christian or non-religious patients. Taken together, these parallels highlight the regional applicability of patient-led, values-based spiritual care that transcends doctrinal boundaries while respecting local cultural and institutional contexts. In the ASEAN context, where pluralism is a lived reality, these findings support the development of locally grounded ISC frameworks^{13,16}.

A one-size-fits-all model imported from the West is insufficient. Instead, spiritual care in Malaysia and the wider region must integrate interfaith practices into healthcare systems, acknowledge diverse meaning-making pathways, and uphold values of compassion, dignity, and respect that resonate across traditions.

Implications for Practice and Policy

Several implications arise from this study. Based on the findings, it is recommended that interfaith awareness modules be integrated into Clinical Pastoral Education (CPE) training to strengthen providers’ competence in engaging sensitively with patients from diverse belief systems. CPE training should incorporate interfaith awareness and inclusive communication modules to strengthen providers’ competence in engaging patients from diverse beliefs with empathy and respect. Additionally, guidelines on family involvement and reflective practice on neutrality should be included to promote ethically sensitive, patient-centred spiritual care in multi-faith healthcare settings.

In addition, the development of multi-faith documentation templates is suggested to ensure that patients’ spiritual needs and preferences are systematically recorded and respected during care planning. Furthermore, shared chaplaincy case discussions involving providers from different faith backgrounds could be encouraged to promote reflective learning and exchange of best practices. These steps would help translate the study’s insights into practical interventions that foster compassion, inclusivity, and cultural sensitivity in spiritual care

delivery.

Second, institutional policies should recognize that spiritual care is not limited to ritual performance but encompasses presence, listening, and family support. Incorporating interfaith-sensitive documentation and referral systems, as suggested in previous reviews, would enhance continuity of care and ensure minority faith patients are supported when faith-specific rituals are requested. Finally, this study highlights the need for a broader cultural shift in Malaysian healthcare, where ISC is seen not as an exception but as an integral component of holistic, patient-centred care. By embedding compassion, respect, and inclusivity at the heart of practice, Shariah-compliant hospitals can model interfaith sensitivity while remaining true to their ethical foundations.

This study has several notable strengths. First, it centred the voices of non-Muslim patients, an under-represented group in Malaysian healthcare research, particularly within Shariah-compliant hospitals. Second, the inclusion of participants from diverse backgrounds—Buddhism, Christianity, Hinduism, Orang Asli traditions, and atheism—allowed the study to capture a wide range of experiences and plural expressions of spirituality. Third, the use of multiple data sources, including non-participant observations and informal interviews, enhanced credibility through triangulation and provided rich contextual detail. Finally, the study's setting in a Shariah-compliant hospital offered novel insights into how ISC is experienced within an Islamic institutional framework, providing empirical evidence to inform the development of culturally sensitive models of care.

Several limitations must also be acknowledged. This study was conducted in a single hospital, which may limit transferability. As patient recruitment was facilitated by nurses, selection bias and social desirability may have influenced responses. The absence of audio recordings might have reduced nuance, though this was mitigated through immediate fieldnote expansion and participant validation. The small, uneven sample across faith groups also limited deeper exploration of individual traditions. Some participants gave brief or limited responses, possibly due to cultural politeness or reluctance to critique an Islamic institution, which restricted the richness of some accounts. Data were collected only during hospitalization, without longitudinal follow-up, limiting insights into pre-admission and post-discharge experiences. Language barriers also affected some encounters, particularly with Orang Asli and foreign patients, in which family members sometimes served as interpreters. Lastly, as all providers were Muslim-trained, patients' responses may have been shaped by respect for religious authority, potentially influencing their openness in sharing. Future research should adopt a multi-site design across hospitals with varying religious or secular orientations, enabling comparative insights and greater diversity of participants.

CONCLUSION

This study contributes to global ISC discourse by showing that non-Muslim patients in a Malaysian Islamic hospital valued universal values, provider presence, and diverse meaning-making. Similar lessons apply in ASEAN: in Singapore's secular system, compassion and presence foster inclusivity, while in the Philippines' Christian chaplaincy, respect for minority voices remains vital. Overall, patient-led, values-centred care can strengthen spiritual inclusivity across plural societies.

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AUTHOR CONTRIBUTION

Shariff NM: Designed the study, data analysis and drafted the manuscript

Pien LS: Contributed to data interpretation and critical revision

Ahmad N: Assisted in data collection, proofreading, and editing

All authors approved the final manuscript

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