JBIMA Journal of the British Islamic Medical Association

Islam & Health

Vol. 3 - No. 1 | December 2019 | www.jbima.com

The Role of Muslim Chaplains in Health Care

John F. Mayberry DSc MD LLM FRCP *Professor of Gastroenterology, University of Leicester & Research Fellow, Muslim College, Cambridge*

Abstract

This is a review of the role of Muslim Chaplains in the healthcare system. It considers their emergence in a community which has no tradition of chaplaincy and issues concerning gender. The conflict of a spiritual role with requirements of government bodies such as NHS England is considered. Its role as a driver to seek an evidence base for chaplaincy is set in the context of current research on the efficacy of prayer in producing improved health outcomes. Attention is given to the wish of many patients, both from a Muslim and Christian background for their clinicians to pray with and for them. The potential implication this has for clinical practitioners when reported to their regulatory bodies is assessed. The consequences and their impact on training of future Muslim Chaplains are then reviewed.

Who are the spiritual caregivers in the Muslim community and what do they do? Arabic contains no word comparable to chaplain and the concept of someone whose profession is spiritual support is alien to a faith in which care and concern for family and neighbours should be an integral part of daily life. The situation becomes even more uncertain when this role is fulfilled by a woman. (1) Some of these issues have also influenced the attitude of health services management to the integration of Muslim spiritual care into the daily activity of hospitals, health centres and community services. Despite an increased interest in the potential benefits that spiritual care can bring to patients' overall welfare in countries as varied as the USA and Iran, there are still organisations, such as the National Health Service, which seem intent on neutralising the beneficial impact that trained chaplains could have on the health of individual patients:

"'The NHS Chaplaincy programme is part of NHS England's drive to ensure good patient care and compliance with policy and legislative drivers." (2)

Ways in which this is being achieved include integration into the NHS pay system for on-call and out-of-hours working. (3) However, as to what the legislative drivers might be is another matter.

Swift has drawn attention to a disturbing aspect of modern chaplaincy. He has suggested that within the NHS Anglican chaplains who have experienced difficulties inside the conventional church structure can find a niche and it is potentially possible that such issues have contributed to creating barriers between patients and spiritual support.(4) Although there is no comparable clerical structure within Islam, the concept that those who do not fit readily into their community's spiritual diorama could find a future within hospital chaplaincy needs to be resisted robustly. The chaplaincy needs open-minded, informed and appropriately educated people whose motivation is the service of patients.

Both high quality clinical care and spiritual care may well be contrary to "compliance with policy and legislative drivers." (2) However, Stewart has suggested that, in practice, spirituality "is being wheeled out by the health service as an agent for manipulation of people" (5). Linked to this emerging philosophy many chaplains in the United Kingdom (UK) and Australia feel compelled to develop an evidence-based approach to health care chaplaincy. (6) This is despite the fact that there is already an extensive research base assessing the effect of prayer on a range of outcomes. Prayer is an activity which distinguishes chaplains from others working in healthcare systems and is the most controversial. Indeed it can lead to the suspension of nurses and doctors.(7,8) In order to ensure that the religious connotation of "prayer" does not prejudice assessment and publication of such research, "intent" has become the preferred technical term. Such developments are far removed from the basic concepts of care and concern and the role of Allah/God/Y-HW-H which should characterise spiritual support.

In contrast in the USA the core disciplines in palliative care are seen as:

"medicine, nursing, social work and chaplaincy"

Von Gunten sees this situation being driven by the needs of patients and their families and not by the needs of staff or indeed institutions.(9) For many Muslim, as well as Christain communities, there is a wish for clinicians to actively engage on a spiritual level with their patients. This contrasts with the NHS which wants chaplains to conform to policy. Clinicians see the role of hospital chaplains as to:

"Help patient and family find meaning and hope in the transcendant dimension; work with community pastors as indicated" (9)

However, palliative care should not be seen as distinct and different from ordinary care. Patients commonly use faith as a way of coping with disease. For some, disease brings them to a faith they had otherwise neglected or did not have. Competent physicians need to be more aware of this aspect of their patients' lives and ensure they can utilise these beliefs as part of their coping strategy. Chaplains can help:

"the patient and family discuss the questions that matter most deeply to them and that may be essential for them to express candidly as they consider their treatment decisions, hopes, and fears." (10)

In the area of spiritual needs and related issues it is the chaplain who should be the expert, and not the clinician or nurse. In any other area of clinical practice early and appropriate interventions by specialists is seen as good practice. It is to be hoped that a similar understanding of the role of spiritual support comes to be widely recognised throughout healthcare systems

Rassoul considered the concept of caring among Muslims to be "embedded in the theological framework of Islam". (11) For Muslims, illness and recovery are times to reflect upon one's faith and spiritual growth. However, when patients do not receive the level of spiritual and religious care that they require or need, there is growing evidence that physical healing can be delayed and even impaired. In today's pressurised healthcare systems this need often goes unrecognised and in only a few settings is an integral part of patient care.

The Patients

In a recent review of the role of prayer, Muslim patients in Iran and Pakistan were keen that their physicians should pray with them and similar views have been expressed in the USA. (12). Such religious involvement between patient and doctor has been actively discouraged by regulatory bodies such as the General Medical Council. The fear that religious doctors might proselytise for their faith at times when patients were vulnerable has been the foundation for this approach. The difficulty arises where the patient wants such a response from their clinician, nurse or other therapist.

In a qualitative study of 24 patients from 3 different cities in Iran their experience in hospital was investigated. The most common and serious issues were of difficulty in praying and of the need for a "companion" who could act as an advocate, both providing for them and protecting their rights. (13) In a country in which religious needs and spiritual support are openly recognised, such a finding is unexpected. It emphasises the need for greater sensitivity to spiritual needs throughout healthcare systems. Muslims show that they care about each other through frequent contact, conversation, social gatherings, and shared rituals. Health care workers often comment on the presence of family as a source of security and support in times of sickness. During illness and death, visitation is expected, and conveys the significance of being available and attentive to family needs. However, the presence of large family groupings is an alien experience for many health carers from different faiths or cultural backgrounds. Staff do not know how to manage the situation, to whom they should speak or what form of solace they can offer. A study of Muslim women from Illinois, USA identified the key challenges as:

- lack of understanding of patients' religious and cultural beliefs;
- language barriers;
- patients' modesty needs;
- patients' lack of understanding of disease processes and the healthcare system;
- patients' lack of trust and suspicion (14)

One reason behind such issues may be related to the loss of a faith which characterises many in the West. This contrasts with the experience of many Muslims. In a study of 15 older Moroccan and 15 Turkish women from Antwerp and had moved to Belgium as young women, the participants stressed that illness should not be approached passively, but rather fought. (15) They all considered it was their duty to seek treatment. Failure to do so was showing disrespect for Allah. They recognised the omnipotence of Allah and believed that he could reverse the rules of nature. As a reflection of such views their approach to illness was two-fold seeking help from doctors and turning to Allah in grateful prayer. With chronic illness prayer was a mechanism through which patients could accept it and deal with suffering. (15) Perhaps the most surprising aspect of this study was the in-depth theological knowledge expressed by these women. However, when Muslims lack a sound understanding of their faith they consult imams and other leaders.(16) In the healthcare setting such behaviour underlines the need for professional chaplains who can fulfil this role with assurance and knowledge, so as to ensure patients do not believe they are compromising

aspects of their faith. The goal of spiritual care, which such chaplains can provide, is to help the sick find those aspects which give meaning and purpose to life. Its most important components are listening, respect, connecting, reassurance and compassion.

Practical guidance comes from The Crescent of Care nursing model developed by Sandra Lovering, working with Saudi nurses.(17) Amongst other things support for prayer is a key nursing action. Patients need to pray or read the Qur'an before undergoing surgery or radiology procedures, or receiving treatment for in-vitro fertilisation. Nurses can facilitate prayer by giving patients notice of the timing of procedures, or by delaying them until prayers are completed. Patients may request nurses pray for or with them regardless of whether or not the nurse shares the same religious beliefs. Such intertwining of spirituality and caring has long been removed from western medical and nursing practice and is frowned upon by regulatory bodies and organisations such as the NHS. However, links between caring and spirituality are common across the Abrahamic faiths and to deny its existence is to deprive many patients of a core personal value at times of intense need.

The Role of Muslim Chaplains

The provision of professional and culturally competent spiritual care is intrinsic to good quality care and knowledge of the demand for and utilization of these services is essential. In a qualitative study of 15 Muslim spiritual caregivers in Canada by Isgandarova six themes emerged about the nature of effective care:

1. It is rooted in the Qur'an and the Hadith
2. It creates a caring relationship with the patient
3. Muslim scholars are an important source of spiritual care
4. Insights from psychology and the social sciences are a necessary part of spiritual care
5. There is a need for continuing education
6. Styles vary between practitioners. (18)

Professional Muslim chaplains in Canada used social sciences and psychology to structure their visitations. They drew on models of pastoral care, brief psychotherapy, and supportive counselling to provide effective spiritual support and this required appropriate education in religious studies and social sciences. Support for this view comes from Abu-Ras who suggested chaplains could serve as cultural brokers, guiding patients toward health care decisions that are congruent with their beliefs and spiritual needs.(19) Indeed in his seminal work on Pastoral Care in Hospitals Norman Autton, an Anglican chaplain from South Wales wrote:

"The differences between pastoral counselling and spiritual direction will be the greater attitude of permissiveness in the former. The relationship between the chaplain and the patient in counselling will end when problems have been resolved and he is able to act freely and independently. Spiritual direction will continue throughout the patient's life as greater spiritual growth is nurtured and developed." (20)

Almost 50 years ago Autton was encouraging chaplains to make themselves known to clinical staff, despite the fact that they may seem disinterested and even difficult, However, chaplains and clinicians share a common purpose - the service of the patients. As part of a multi-disciplinary team it is to be hoped that Muslim chaplains will help revive spiritual aspects of medical care. (21) Bearing witness to one's faith does not mean proselytising. Rather it is the daily life walk of the chaplain as he or she goes about his or her work that causes others to enquire about what is their inner motivation. The effective chaplain also needs to literally walk around the hospital and be known as someone whom it is easy to approach and talk. (21)

Training

Without proper knowledge of traditional theological education and the theology of health, it is impossible to provide effective Muslim spiritual care to Muslims. The theology of health starts with considering health to be one of the greatest blessings given to human beings. In subsequent centuries Muslim scholars emphasized "holistic medicine," which includes spiritual, psychological, physical, and moral aspects. In Isgandarova's study interviewees had used the works of Said Nursi, Mawdudi, Rumi and Fethullah Gulen in their practice. (18) In the UK there is a view that advanced religious knowledge is needed to be a "good" chaplain (21). Those that hold such views it gives confidence to patients. Unfortunately the study did not give an in-depth insight into what Muslim patients expected of their chaplains or whether indeed they did hold such views. Indeed difficult issues such as withdrawing life support seemed to cause as much consternation to the chaplains as to family members. These anecdotal findings strengthen the need for chaplains to have a sound grounding in the ethical issues that confront clinicians on a regular basis. One role of chaplains would be to help staff through development of a program of seminars and support groups allowing individuals to work through these issues.

In a study of Muslim Chaplains in the UK the use of two English translations "Al-Ghazali on The Ninety-nine Beautiful Names of God" and "The Mantle Adorned" was identified. (21,22,23) Lahaj linked the value of Al-Ghazali's writings to the impact of a life crisis and the rebalancing his writings to have a greater pastoral appeal. (24) Fortress of the Muslim is probably the best known popular devotional collection drawn from the Qur'an

and the Hadith.(25) However, such collections have been popular over the centuries and there are many of them. (26) What is apparent is that there is a need for a range of easy-to-read booklets which chaplains could leave with patients, written in English and addressing issues of concern to patients including topics such as:

1. My doctor is of the opposite sex.
2. Where can I pray?
3. Will the doctors tell me if my medications contain alcohol or porcine material?
4. I would like my doctor to pray with me.
5. I am frightened

Adequate training of Muslim spiritual and religious caregivers can help them assist Muslims with emotional and family problems which cannot be dealt with by a theoretical approach alone but requires practical training and experience. A clear articulation of the relationship between social sciences, psychology and theology, and a style of Islamic spiritual and religious care is needed. (18)

Activities

In some jurisdictions Muslim chaplains will be required to give spiritual support to people of other faiths which can present difficulties for those remaining authentic to their own beliefs and practices. (27) As a result some chaplains learn to neutralize or move beyond religious differences through training in clinical pastoral education which has taught them to listen without judgment and to be present with people without an agenda. (28) However, there is evidence that when a chaplain of a different religious denomination was asked to pray, patients considered the prayer inappropriate, even when a chaplaincy visit had helped the patient address important medical, nursing and administrative issues. (29) Support for this finding comes from the negative impact lack of knowledge about minority patients' spiritual needs has on the chaplain/patient relationship and its effectiveness (30). In addition, in a survey of Muslim and non-Muslim chaplains, some reported that some Muslim patients feared being proselytized by non-Muslim chaplains.(19) Of course the same may be considered true for patients of other faiths who are offered spiritual advice by a Muslim chaplain. This may be one area which distinguishes a chaplain from an imam, whose role is to meet specific liturgical needs within the Muslim community. If an imam is to act as a chaplain, he will need additional education to do the job well. The chaplain is looking at the needs of patients in relation to illness and helping strengthen them. As such Muslim chaplains may also have a role in the wider community where families are beset with a range of domestic, social, and psychological problems. In such a setting a trained Muslim chaplain could provide confidential counselling and support.

Muslim chaplains may be male or female and this can be challenging for all concerned. The nature of the work means that for some Muslims it is a profession in which they would feel uncomfortable. The thought of how to deal with a proffered hand shake, the photograph on the chaplaincy personnel board, choice of dress and working with those of a different faith are issues which need to be thought through during training. For example, although Muslims prefer to respect gender boundaries, the tradition of the Prophet Muhammad shows that male Muslim spiritual caregivers may visit female clients, if there is no alternative solution available. However, if women are uncomfortable dealing with men, this decision needs to be respected and arrangements made to provide all-female care. Within the context of organisations, such as the NHS, where gender boundaries have been broken down this can lead to conflict. If a patient is able to specifically request a chaplain of his or her own gender, should they also be able to specify the gender of the doctor, nurse or physiotherapist?

Linked to these aspects is the role of touch which is an important aspect of interaction, especially involving communication of love and security. (31) Published studies have confirmed significant clinical benefit, including an extensive review of the literature from Iran. (32) Use of therapeutic touch by trained nurses in Isfahan in a controlled study amongst patients about to undergo coronary artery by-pass surgery showed it to lower systolic and diastolic blood pressure as well as breathing rate. (33) However, therapeutic touching amongst Muslim patients in Oman was mostly rejected by patients.(34) Touching is something which may or may not be acceptable to Muslim patients and this means that chaplains need to take an open, considered and informed approach to physical contact with patients.

So what can be expected of chaplains? As Autton wrote chaplains should be:
- Available
- Acceptable
- Adaptable
- Sincere not suave
- Sensitive not superficial
- Servant, not status-seeker (20)

Characteristics which should be found in Muslims and were described in Nahj al-Balaghah, (Sermon 193) as:
1. having clear, plain, non-obfuscating speech
2. wearing moderate dress
3. comporting themselves in a measured and humble manner
4. keeping their eyes closed to that which Allah has ordained unlawful
5. keeping their ears open only to beneficial information (35)

Once in post Muslim chaplains have a role in:

• providing education about basic religious and cultural beliefs
• promoting collaborative patient-provider relationships
• addressing language-related communication barriers
• patient education about disease processes and preventive healthcare.

Language, cultural and religious differences give rise to well recognised barriers to efficient patient care and communication and are common amongst Muslim patients. (36) This can have implications for which services Muslims are willing to accept. Muslims may not recognise there is a difference between un-Islamic practices and non-Islamic practices. They can be faced with accepting empirically based practices that are packaged as being within an Islamic framework or new interventions that are based primarily on Islamic principles and borrow from evidence-based medicine. (16) Examples include use of alcohol containing oral anaesthetic sprays in endoscopy and prescription of porcine based medications such as pancreatic supplements.(37,38) In both cases approved alternatives do not exist and discussion with an informed Muslim chaplain can help guide the patient as well as better inform the clinician.

Inclusion within the multi-disciplinary team and the development of close links with clinicians and nurses allows a chaplain to be more effective as both teacher and carer. The Muslim chaplain should be an authentic advocate for Muslim patients, reflecting the sensitivity and respect of the hospital for religion and culture. His or her presence can help build trust between doctors, patients and family. When this relationship exists it gives credibility to the transparency and motives of the entire medical team. Indeed in those too common institutions which pay only lip service to the role of spirituality and chaplains in the care of patients these relationships will not exist. The chaplaincy is marginalised, the prayer room will be little more than a cupboard which can only be accessed through a hospital swipe card, and the chaplain will seldom be seen on any ward, where he or she is an unwelcome visitor who is only summoned when the nursing staff are pressurised to do so by an anxious family.

Regulation

In the UK, the NHS employs chaplains and regulates what they can and cannot do. They are in a similar situation to any other NHS employee, their professional responsibility lies with the spiritual group of which they are a member. For example about 50% of Muslim chaplains in the UK are Deobandists with the other half coming from a range of backgrounds. (39) As a result in the UK there is a need for an active association of Muslim chaplains working within the NHS to promote good standards of practice and to encourage networking between individual practitioners. Indeed such an organisation could allow a more effective inter-faith stance when dealing with the bureaucracy of the NHS and promote the values common across the monotheistic faiths. In the USA the Association of Muslim Chaplains has as its pledge taken by all members: "I, as a Muslim chaplain, pledge to serve Allah (God) in accordance with sound Islamic principles: service to humanity, sincere advice, equity, respect for human dignity, and justice. I will obey the Islamic teachings, love the Compassionate God with all my heart and soul, and serve the people who seek my help, counsel, and advice with compassion, sincerity, and integrity."(40)

The emphasis is on serving the people who seek help and counselling – interestingly a term which encompasses all people.

Acknowledgement

This work was supported through a grant from the Templeton Foundation

References

1. Lahaj M Making it up as I go along: the formation of a Muslim Chaplain Volume 29 Forming Religious Leaders in and for a Diverse World http://journals.sfu.ca/rpfs/index.php/rpfs/article/view/231 (Accessed 19/1/2017)

2. NHS Chaplaincy Guidelines 2015 Promoting Excellence in Pastoral, Spiritual and Religious Care https://www.england.nhs.uk/wp-content/uploads/2015/03/nhs-chaplaincy-guidelines-2015.pdf (Accessed 24/1/2017)

3. Eccles JB (2014) The Chaplaincy Experience: Negotiating (multi-faith) Time and Space in a Northern English General Hospital. Journal of Pastoral Care and Counselling 68: 1 – 12

4. Swift C (2014) Hospital Chaplaincy in the Twenty-first Century. The Crisis of Spiritual Care on the NHS. Ashgate Farnham

5. Stewart J (2003) Theological considerations in chaplaincy development: Humanity, modermity and postmodernity, conference paper (Leeds 2003)

Quoted in: Swift C (2014) Hospital Chaplaincy in the Twenty-first Century. The Crisis of Spiritual Care on the NHS 2nd Edition Ashgate Publishing Ltd Farnham

6. Fitchett G (2011) Make our case(s) Journal of Health Care Chaplaincy 17: 3 - 18

7. Christian doctor sacked for emailing a prayer to colleagues to cheer them up loses appeal against dismissal (2013)http://www.dailymail.co.uk/news/article-2431814/Christian-doctor-sacked-emailing-prayer-colleagues-

cheer-loses-appeal-dismissal.html (Accessed 26/1/2017)

8. Experienced nurse fired from job after offering to pray for patients waiting for surgery http://www.telegraph.co.uk/news/2016/12/11/experienced-nurse-fired-job-offering-pray-patients-waiting-surgery/ (Accessed 26/1/2017)

9. Von Gunten CF (2002 Secondary and tertiary palliative care in US hospitals Journal of the American Medical Association 287: 875 – 881

10. Jacobs MR (2008) What are we doing here? Chaplains in contemporary healthcare. Hastings Center Report 38: 15 – 18

11. Rassoul, G. (2000) The crescent and Islam: Healing, nursing and the spiritual dimension. Some considerations towards an understanding of the Islamic perspectives on caring. Journal of Advanced Nursing 32: 1476–1484

12. Mayberry JF (2019) Health, Prayer and Spirituality: A Review of the Muslim Contribution. Submitted for publication

13. Karimollahi M, Abedi HA & Yousefi A (2007) Spiritual needs as experienced by Muslim patients in Iran: a qualitative study. Research Journal of Medical Sciences 1: 183 – 190

14. Hasnain M, Connell KJ, Menon U & Tranmer PA (2011) Patient-centered care for Muslim women: provider and patient perspectives. Journal of Women's Health 20; 73 – 83

15. Baeke G, Wils J-P & Broeckaert B (2012) "Be patient and grateful" –Elderly Muslim women's responses to illness and suffering. Journal of Pastoral Care and Counselling 66: 1 – 9

16. Ali OM (2016) The Imam and the mental health of Muslims: learning from research with other clergy. Journal of Muslim Mental Health 10: 65 – 73

17. Lovering S (2012) The Crescent of Care: a nursing model to guide the care of Arab Muslim patients. Diversity and Equality in Health and Care 9: 171–8

18. Isgandarova N (2012) Effectiveness of Islamic spiritual care: Foundations and practices of Muslim spiritual caregivers. Journal of Pastoral Care and Counselling 66: 1 – 16

19. Abu-Ras W (2011) Chaplaincy and spiritual care services: the case for Muslim patients.
Topics in Integrative Healthcare 2: 1 – 16

20. Autton N (1969) Pastoral Care in Hospitals SPCK London

21. Gilliat-Ray S, Ali M & Pattison S (2013) Understanding Muslim Chaplaincy Ashgate Farnham

22. Burrell D & Daher N (1995) The Ninety-nine Beautiful Names of God Islamic Text Society Cambridge

23. Murad AH (2009) The Mantle Adorned. The Quilliam Press Ltd London

24. Lahaj M (2011) End-of-life care and the chaplain's role on the medical team. Journal of the Islamic Medical Association of North America 43: 173 – 178

25. Al-Qahtani SW (2009) Fortress of the Muslim. Invocations from the Qur'an and Sunnah, Darussalam Riyadh

26. Padwick CE (1997) Muslim devotions. A Study of Prayer-Manuals in Common Use, OneWorld Publications Oxford

27. Kowalski M, Practical theology for Muslim Chaplains in CPE, Volume 29 Forming Religious Leaders in and for a Diverse World http://journals.sfu.ca/rpfs/index.php/rpfs/issue/view/47d (Accessed 19/1/2017)

28. Cadge W & Sigalow E (2013) Negotiating religious differences: the strategies of interfaith chaplains in healthcare. Journal for the Scientific Study of Religion 52: 146–158

29. van de Creek L & Lyon M (1997) Ministry of hospital chaplains: patient satisfaction. Journal of Health Care Chaplaincy 6: 1- 61

30. Hamza DR (2007) On models of hospital chaplaincies: which one works best for the Muslim community? Journal of Muslim Mental Health 2: 65 – 79

31. Autton N (1989) Touch. An exploration. Darton, Longman & Todd London

32. Tabatabaee A, Tafreshi MZ, Rassouli M, Aledavood SA, Majd HA & Farahmand SK (2016) Effect of therapeutic touch in patients with cancer: a literature review. Medical Archives 70: 142 – 147

33. Zare Z, Shahsavan H & Moeini M (2010) Effects of therapeutic touch on the vital signs of patients before coronary artery bypass graft surgery Iran Journal of Nursing and Midwifery Research 15: 37 – 42

34. Muliira JK & Muliira RS (2013) Teaching culturally appropriate therapeutic touch to nursing students

in the Sultanate of Oman. Reflections on observations and experiences with Muslim patients. Holistic Nursing Practice 27: 45–48

35. Hegedus A (2010) The theology that underpins Islamic chaplaincy, The Journal of Health Care Chaplaincy 10: 50 – 54

36. Mayberry JF & Farrukh A (2012) Gastroenterology and the provision of care to Panjabi patients in the UK Frontline Gastroenterology 3: 191-198

37. Farrukh A & Stewart J (2014) An audit of lidocaine spray and its use in endoscopy with particular attention to its ethanol content. Journal of Digestive Endoscopy 5: 18 – 21

38. Mayberry JF (2014) Digestive enzyme supplements: replacement therapy for individuals unwilling to take porcine products. British Journal of Hospital Medicine 75: 474 – 475

39. Religion and Society (Undated) Muslim Chaplains are changing Chaplaincy, and Chaplaincy is changing Islam in Britain. http://www.religionandsociety.org.uk/uploads/docs/2012_09/1348659246_Gilliat-Ray_Phase_1_Large_Grant_Block.pdf (Accessed 26/1/2017)

40. Association of Muslim Chaplains http://associationofmuslimchaplains.com/code-ethics-2/ (Accessed 26/1/2017)