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Editorial

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Editorial

Dr Sharif Kaf Al-Ghazal, *Editor in Chief*

Assalamo Alaikom

The increase on the focus of issues within Islamic bioethics is a welcome development, and this month (December) alone, 3 Islamic medical conferences have taken place. Our BIMA conference in Birmingham, the conference in Istanbul (Turkey) which focused on the Fatwa-making for medical issues, and the conference on bioethics and Islamic perspective in Toronto (Canada). These conferences have stimulated significant discussion on the Islamic rulings on various medical issues and have inspired others to lead research to understand these areas better. When one speaks of Islamic bioethics, it is usually regarding the rulings of Islam towards biomedical challenges and the advancement of medicine; as well as the beginning and end of life. It is imperative for us to study how the fatwa rulings develop in these areas as society develops.

There is one area in Islamic bioethics which seems to be slightly neglected however; the importance of the patient - physician relationship. This is a crucial area of understanding and determines the success of the physician. The required character of the Muslim physician is high though this does not seem to be as well understood. Perhaps this is due to the assumption that a physician should be of the best character anyway. Interestingly, it is the literature written by prominent Muslim physicians that has influenced this as will be set out below.

A Muslim physician should be talented and knowledgeable. These qualities are obvious of course, but a Muslim physician's knowledge should not merely extend to medicine alone. He should be well read about the world around him and have a basic understanding of other disciplines. After all, medicine does not exist in a vacuum; it is not an isolated profession and a patient who will be unwell may have a number of aggravating factors that relate to different disciplines.

It is of course imperative that a Muslim physician be of good character and be trustworthy and honest with his patients. He should be just and fair and not treat any patient with an element of favouritism. Whilst he will prioritise the most severe cases, those which are less severe should not be forgotten about and dismissed. The physician has a fundamental duty of care towards patients and it is critical that this duty is upheld at all times. Confidentiality of the patient has to be respected. A Muslim physician should not bring the medical profession into disrepute through his poor character.

A Muslim physician should present himself well but remain modest too. It is a mark of respect towards one's patients to be dressed and groomed appropriately though the clinic and hospital are not fashion parades. Remembering that some patients may not be as wealthy as the physician is important; the physician is their peer and should – to a certain extent – look and dress like them. This helps him be seen in a positive light.

There is a duty towards the Muslim physician to respect their colleagues' specialties. Everyone's knowledge is finite; no individual is an expert in every speciality and a good physician should be humble enough to understand that there will be medical areas where he should defer to his colleagues' judgement. The medical field is a broad sphere after all.

Furthermore, a Muslim physician has a duty towards his students is to not be secretive with his knowledge and share it to improve the lives of others. There is little use of such knowledge being gained through extensive research and practice if it is not shared. The physician's students will take over from him one day; it is their right to be taught in the best possible way. As previously mentioned, he is instructed to be humble and should not be shy in seeking their input and knowledge even though they are students. He should be tactful in criticising them (and not do so in front of their peers) and avoid humiliating them.

The Muslim physician's duties towards his elders (amongst physicians and those of other disciplines) is to respect them unconditionally but to advise sincerely without fear when they are wrong. His duties towards society are to help with health promotion and public health campaigns. He should play a part in raising awareness of various health concerns affecting the society of the time.

And ultimately, a Muslim physician's duties towards humanity are to help facilitate aid and relief campaigns

towards disaster stricken areas around the world and to take part in research towards cures. Disease does not discriminate between the old and young. Rich and poor. Black and white. A Muslim physician is capable of making a difference to millions around the world he will never meet with work in research and in aid relief.

Whilst the General Medical Council places a lot of emphasis on these qualities within the revalidation process and 360 reviews as well as the yearly appraisals, it is clear that Muslim physicians have been doing this for centuries. The book (Adab Al Tabib) Ethics of Physician by Rahawi in the 9th century and also Al Razi in his book (Akhlaq Al-Tabib) Manners of Physician, touch on these issues in such detail. It is another example of Islamic practice leading the way, centuries in advance.

JBIMA encourages papers on this in the future and strives to ensure there is more awareness of the importance of the character of the Muslim physician and his good relationship with the patient.

Very best wishes,

Wassalam.

Dr Sharif Kaf Al-Ghazal

JBIMA, Editor in Chief

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Ethics

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Contemporary Topics in Islamic Medical Ethics

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Abstract

The Islamic guidance on practical issues related human life in particular can be sought in Islamic medical ethics. Medical ethics is known for its controversial issues . The most important aspects of Islamic medical jurisprudence may be the rules on the new methods and techniques provided by tremendous advances in medicine and the moral changes of the societies.

The aim of this paper is to highlight the Islamic view on commonly encountered issues in medical ethics, and explore their applications in daily practice.

Introduction

Islam holds that ethics cannot be divorced from morality and ethics are not to be split from law. Islamic law is a compendium of ethics, morality and legal rules. Islam considers medical ethics the same as ethics in other aspects of life.[1] Contemporary issues such as that related to fertilization, and termination or prevention of pregnancy, organ transplantation, end of life issues, stem cell research and cloning etc. should be clearly discussed and presented to the health care providers.

In this paper, we have highlighted the importance of knowledge and understanding of the Islamic rules on different emerging issues in medical ethics and explored their applications in daily practice. Once equipped with such knowledge, it may be possible for the health care provider to move forwards, and deal with the ethical problems faced in real-life with more confidence.

1. Abortion

In Islam, the core of the family unit is the cornerstone of society and marriage is the only acceptable way of procreation. Procreation is considered to be a spiritual act of worship and anything that may put the pure progeny in danger is prohibited.

Abortion, defined as the termination of a pregnancy before the infant can survive outside the uterus, has always been a sensitive issue in the Islamic world. It is interesting to note that the three most prominent religious groups; Judaism, Christianity, and Islam have very strict ethical rules regarding a highly controversial issue like abortion. Life is the divine creation of God and ending a life, especially that of a child is strictly prohibited. Muslim laws do not specifically designate the title of a human being for the embryo until the 'ensoulment' which occurs in the 120th day from the time of the fertilization of the ovum (i.e., conception). [2]

Although Islamic teachings support the act of procreation, temporary means of contraception are not prohibited within the state of wedlock with the consent between the spouses.[3] Sterilization is strictly forbidden, except for medical purposes when a pregnancy would seriously endanger the life or the health of the expectant mother.

In almost every Muslim country, abortion is prohibited except in the case of a medical situation when the pregnancy could endanger the life or health of the expectant mother or when there is a severe congenital anomaly found in the fetus.2 If the malformation is untreatable, unmanageable and very serious, then abortion may only be carried out prior to the 120th day of conception (calculated from the day of fertilization, not from the last menstrual cycle). Beyond 120 days, (i.e., after the ensoulment,) abortion is only allowed if there is a danger threatening the mothers' life and not only her health.4 The decision to abort would be made by a committee of at least three knowledgeable physicians who present clear medical indications.

Furthermore, some jurists agree that the rules related to abortion should be extended to incidents like rape. There are many Fatwas penned by the Islamic Fiqh Council of Islamic World League, Makkah Al Mukaramah, the International Islamic Fiqh Academy of Organizations of Islamic Conferences and other organizations which permit an abortion following rape. The law states that it should be carried out within the first 40 days of pregnancy.[2,3,4] No school of Islamic jurisprudence has permitted abortion as a means of birth and population control, or to avoid economic hardships. In the Islamic world, there is a strict punishment for anyone using any means to cause a miscarriage. The person responsible for the crime must pay an indemnity (1/20 of adult diyah) to the woman's family.

2. Assisted Reproductive Technology

In the Qur'an, it is said that "wealth and progeny are an adornment for the life of this world."[5] Since Islam strongly supports a high fertility rate, it is permissible to seek a remedy for infertility as it is not acceptable to adopt a child. The Islamic rule is quite clear; infertility does not make anyone less of a man or a woman.[6] It is encouraged to implore God for a suitable blessing.

All types of reproductive technologies are acceptable in Islam if they involve the semen, ovum, and the uterus of a legally married couple.[7,8] The determination according to law is that if there is no cure for infertility, it should be accepted.

Assisted Reproductive Technology (ART), which makes it possible to use a donor's sperm to have children, is prohibited according to Islamic law. Furthermore, the international practice of ART that involves sperm, ovum, and embryo donation is incompatible with the Islamic worldview.[9] Surrogacy is forbidden in Islam.[10]

In Vitro Fertilization is permitted under the Islamic law in cases where the following conditions are met: the couple should be married, the process should use the sperm of the husband and the eggs of the wife, the marriage should be authentic at the time of the process, and the team carrying out the process should be competent and professional in order to avoid any chance of mistake.[8,9]

The appropriate number of fertilized eggs should be transferred to the uterus. It is common to transfer two or three eggs. It is permitted to freeze the remaining fertilized eggs for the future use for the same purpose by the same couple if they are still married when the process takes place. In case of divorce or the husband's death, it is prohibited to use the preserved sperm. What about the fate of remaining eggs?. The rule in Islam allows the eggs to be used for research purposes with the consent of the couple. However, and as early as 1990, the International Islamic Fiqh Academy of Organizations of Islamic Conference declared its position and refused the premise of freezing eggs since there is even a remote chance of mixing between gamets or preembroys.[3] The wife is allowed to use the sperm of her imprisoned husband to impregnate through artificial insemination.

Gender selection for medical reasons is permitted. However, it is not allowed to choose the sex of the fertilized ovum for social purposes. [9, 11]

3. Ethical Issues in Genetics

Genetic and congenital disorders are more common occurrence in Arab states than in industrialized countries.[12] There are several reasons attributed to this high rate of genetic disorders:

- High consanguinity rate, 25-60% marriages are between relatives.[13]

- The prevalence of widely spread disorders like hemoglobinopathies, glucose-6-phosphate dehydrogenase deficiency, autosomal recessive syndromes, and other metabolic disorders.

- The birth of children with Down's syndrome is higher in Arab countries as compared to the industrialized ones. It is thought that this disorder is in part, the result of the fact that older women living in rural areas continue to give birth. The higher age is thought to lead to the birth of a Down's syndrome child. Late pregnancy in the West can increase the Down's syndrome but they usually resort to abortion to avoid the birth of Down's syndrome babies.

- The lack of public health measures, such as premarital counseling, especially in poorer countries, may contribute

to the higher rates of genetic and congenital disorders, and the failure to assist affected pregnant with new techniques such as preimplantation genetic diagnosis technique during pregnancy. Such services are sometimes forbidden because of cultural, legal or religious limitations.

In several Arab states, it is mandatory to undergo a premarital medical examination. There may be cases when the couple would be advised not to marry. However, the final choice is theirs. The positive outcome of this process is the reduction of autosomal recessive blood disorders.

A pre-implantation genetic diagnosis is allowed in Islam if a third party is not involved in the process. This process decreases the risk of having a baby with a genetic disease and consequently avoid abortion.[14]

The Islamic position towards genetic engineering stresses its usage for disease prevention, disease treatment, obtaining benefits in agriculture and food industries, and to do no harm to the society and the environment.

Cloning is also prohibited in Islam. It is acceptable, however, to use genetic engineering and cloning in the field of microorganisms, plants, and animals if the result would be more beneficial than harm.[15]

Although stem cell research is allowed in Islamic countries, the creation of an embryo for the purpose of research is prohibited. In stem cell therapy, a bone marrow transplant is used to treat blood disorders such as leukemia, thalassemia, etc. Stem cell research used for therapeutic purposes is permitted if they meet certain conditions. These are: having the full consent of the adult and the guardian in the case of children, the permission of the parents to use the placenta or the umbilical cord, if a fetus is aborted; and if the leftover zygotes remain after In Vitro Fertilization (IVF).2 All of these conditions are acceptable as long as they cause no harm. Any illegally received material cannot be used for the research.[16]

The ethical issues and Islamic view related to mitochondrial replacement therapy and Gene Germline editing using CRISPER-Cas 9 technique, will be discussed by the Islamic Fiqh Academy of the Organization of Islamic Conference in their meeting to be held in Dubai on 4-6 November 2019.

4. End-of-Life Ethical Issues

In Islam, mercy killing, euthanasia, is prohibited even if a patient chooses that path and the family members agree with that decision. Life is considered to be a sacred virtue and only God can end the life of a person. No one is allowed to deliberately end his life, or that of another human being. Saving a life is encouraged, and reducing suffering with analgesia is however acceptable, even if, in the process, death is hastened.17 Research on this subject denies the effect of morphine to cause death, if it is given in the proper dosage.

Many companions of the Prophet Muhammad (PBUH) refused therapy in their last illness, as they felt it would be futile, e.g., Abubaker Assidiq - the First Caliph. When it was clear that his life was reaching an end, he refused treatment with what he called 'useless treatments.' His wish was not to be treated and that request, which was honored, was in no way equated with him taking his own life. Furthermore, a Muslim person cannot commit suicide since God is the one who gives and takes life. It is believed that transgressors are responsible for their actions and will be punished in the Judgment Day.[17, 18]

Allowing a patient whose case is considered futile to die by not providing a ventilator or withholding cardiopulmonary resuscitation is not the same as killing a person. The Islamic concept concerning Do Not Resuscitate (DNR) decision has been clarified by the Presidency of the Administration of Islamic Research, Riyadh, KSA, in their Fatwa No. 12086 issued on 28/3/1409 (1989). The Fatwa states that: "if three knowledgeable and trustworthy physicians agreed that the patient condition is hopeless; the life-supporting machines can be withheld or withdrawn. The family members' opinion is not included in decision-making as they are unqualified to make such decisions".[19] Preventing nutrition and hydration to a person is regarded as a form of murder according to the Islamic jurisprudence. The practice of holding the nutrition and hydration in a patient may lead to a painful death.[20]

5. Organ Transplantation

Organ transplantation is not a new process; it has been used by Muslims for centuries. The use of an animal bone from a slaughtered (Halal) animal or from a corpse (Carcass) or of porcine origin, are allowed when there is no other alternative. A personal view of Zakaria Al Qazwini (600-682H/1203-1283AD), a grand Judge in Iraq, stressed that the porcine bone is better and more functional for transplantation than any other xenografts.[21]

Religion is an integral part of the Muslim society, and continues to have an essential role in decisions regarding organ transplantation. Several Fatwas, stating the details about the permission of organ transplantation have been issued.[22]

Even after the departure of soul and confirmation of death, the body should be respected; mutilation is not permitted. Cremation is prohibited as well. The body should be buried as soon as possible to avoid putrefaction. If an organ is removed from a corpse, the benefits should clearly outweigh the harm. A person cannot donate his/her vital organs since it can cause death/suicide which, in Islam, is

as much a crime as a homicide and is one of the greatest sins one could commit. If the donation does not cause much harm and a patient's health can benefit from it, it is encouraged to be an organ donor. In the Islamic belief, the donation is viewed as an act of charity, altruism, and a genuine love for humans.[4,23]

During the 20th century, Muslim jurists sanctioned blood transfusions, although blood is considered to be Najas (unclean). In 1986, during the Third International Conference of Islamic Jurists, the participants passed a resolution which defined brain death and equated it to cardiac and respiratory death[3] This decision provided the possibility to expand organ transplantation projects which included only living donors. In 1990, during the Sixth International Conference of Islamic Jurists, the participants discussed the issue of genital organ transplantation. They prohibited the transplantation of gonads since they are the carriers of the primary genetic material from the donor. Despite that finding, they sanctioned the process of transplantation of other internal sex organs.[3]

In his editorial, Kaf Al-Ghazal[24] pointed out that the issue of organ donation still remains an incredibly important one attracting a lot of discussion amongst medics, ethicists, healthcare policymakers and wider society. It stimulated a lively debate within the Muslim community in UK with a recent positive shift towards organ donation.[24]

The practice of organ trading is prohibited in Islam. No financial incentive to the donor or his relatives for giving his organs. The government, however, can encourage donation by giving medals and special services to the donor and their families.

There should be no cost to the family of the donor for removing the organ and any permanent harm to the donor must be avoided.[4]

Organ donation should be made in accordance with the living donor's wishes and intentions and his/her decision should be thoroughly respected. In case of death of a person, his family can make a decision for organ transplantation. It is also permissible for a Muslim to donate or accept organ/s from a non-Muslim.[25]

6. Brain Death

According to Islamic belief, there is no true consensus about brain death. Some equate it to cardiopulmonary collapse; others consider it something between life and death when the life support should be continued.[26] Death in Islam is the departure of the soul from the body. The soul remains eternal, but it will be chastised or eulogized until the resurrection day when it will reunite with the body and go to Paradise or Hell. Death is the result of the permanent loss of brain functions. The loss can occur as a result of either an intracranial cause like major trauma or hemorrhage or from an extracranial cause such as cardio-respiratory arrest. Three primary criteria medically determine death and provide complete evidence regarding the final diagnosis. They are: somatic (external features on the body), circulatory (after cardio-respiratory arrest), and neurological (patients in a coma on mechanical ventilation).[27]

In Saudi Arabia and several other countries, in addition to the stringent clinical criteria used for the diagnosis of brain death, there are specific criteria that has to be observed in the case of brain death. The electroencephalogram (EEG) of 30 min duration should be silent , and there is a suggestions to confirm the absence of blood flow to the brain as determined by a Doppler, cerebral angiogram, computed tomography (CT) angiography or magnetic resonance imaging (MRI) angiography etc.[28]

In the Fatwa of 1982, the Senior Religious Scholars of Saudi Arabia discussed the issue of organ donation received from living as well as deceased patients. The Fatwa of the Islamic Fiqh Academy of the Organization of Islamic Conference (October 1986) provided a legal definition of death in Islam: either an individual has sustained total cessation of cardiac and respiratory functions and it is irreversible or there is permanent complete cessation of all cerebral functions and the brain is disintegrating.[3, 28]

Although guidelines are available in many countries to standardize national processes for the diagnosis of brain death, the current inconsistency in practice make it imperative that an international consensus is developed. This should clarify the criteria for the determination of brain death and provide specific instructions about the clinical examination. It should also stipulate the role and type of confirmatory investigations and detail the required level of documentation.[27]

Islamic juridical deliberations around brain death largely took place over 30 years ago in response to medical developments and ethical controversies in the Western world. The debates within Muslim bioethics need updating and deepening concerning the early rulings on brain death.[29]

Conclusion

Religion is an integral part of a Muslim's life. Among health care providers, there is a definite need for more awareness of Islamic medical jurisprudence. Muslim caregivers are required to think through bioethical issues from an Islamic point of view. In daily practice, the Islamic rules on several ethical issues should be clear and concise to the health care providers. A Simple booklet containing recent version of the Islamic code of ethics, common ethical dilemmas, and currently evolving ethical issues should be available for all health professionals treating Muslim patients.

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Bioethics of End of Life Medical Care

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The cardinal purposes of the Muslim's individual, community and global life experiences have been comprehensively defined by the maqasid al- shari`ah, the highest objectives of Islamic jurisprudence. The wellbeing and welfare of the community is protected by the preservation of the five essentials (daruriyyat) in human life, namely faith and morality (din), life (nafs), intellect ('aql), progeny (nasl) and wealth (mal) [1].

In the hierarchy of the maqasid al-shari`ah, the sanctity of human life is prioritised, second only to the preservation of din. Life is a divine gift and trust from Allah (ﷻ) and its protection and continuation is of utmost urgency and importance.

"And if anyone saved one life, it would be as if he had saved mankind entirely"[2].

Allah, the Life Giver (al-Muhyi) is also the Life Taker (al-Mumit).

"He gives life and causes death (yuhyi wa yumit), and to Him you will be returned" [3].

The following prayer taught by the Prophet (ﷺ) reiterates the fact that only Allah (ﷻ) decides and determines the timing of life and death:

"O Lord! Please let me live if that is for my good and please let me die if that is better for me"[4].

Death marks the departure from the continuum of temporal life here on earth and a journeying towards eternal life in the hereafter. We are exhorted to invest our life righteously so as to enjoy the fruits in the life hereafter. We are regularly reminded to prepare for the afterlife and central to this exhortation is the constant preparedness for death

Life and death issues become even more pronounced and complicated with end of life care and the myriad of clinical choices available. Advances in medicine and surgery have revolutionized the care of patients with cancer, cardiac disease and others with major organ failures. There have been improvements in the morbidity and mortality rates of the critical and terminal patients, however with variable and questionable betterment of their quality of life. The power of the science of healing has somewhat overwhelmed the art of healing and has unwittingly unleashed new sets of clinical, ethical, legal, cultural and religious issues which now challenge our objectives and ethics of end of life care.

Physicians, patients and their families are faced with extremely perplexing and painful dilemmas which include among others:

- How much more should we allow our loved ones to suffer?
- Should we explore all treatment options even though the prognosis is poor?
- Should we allow the respirator, and other life support modalities, to be disconnected upon the advice of the attending clinicians?
- Should we consent to Do Not Resuscitate orders (DNR)?
- How much longer can we afford the care of our loved ones in the ICU?

The Federation of Islamic Medical Associations (FIMA) first formally addressed these difficult yet important end of life care issues in our 2002 and 2005-06 Year Books [5,6]. With the plethora of life-saving interventions, sophistications of therapeutics and intensive care modalities, we felt that it was pertinent to re-examine a wider range of these end of life issues, from the perspectives of maqasid al-shari`ah, as the third part of the Encyclopedia of Islamic Medical Ethics [7].

We have comprehensively addressed and updated the scientific and medical developments of end of life care, as well as analysed the psychosocial, ethical, legal and Islamic perspectives.

I have summarized the practical and key messages from these excellent reviews of major issues related to end of life care which are relevant to the daily practice of physicians who care for the critically ill or terminal patient :

• Global life expectancy in 2015 was 71.4 years, ranging from 60.0 years in the WHO African Region to 76.8 years in the WHO European Region. Global average life expectancy increased by 5 years between 2000 and 2015. A thorough and contemporary understanding of the effects of aging on the various systems in the human body is a basic essential towards framing a holistic program for end of life care and its unique challenges. Apart from addressing their physical, cognitive and psychological needs, we must not neglect their continuing roles in society and benefit from their talents, experience and wisdom.

• Like all other specialties of medicine and surgery, a Muslim physician's approach to the specific issues related to end of life management must be understood within the context of disease and its treatment in the Islamic paradigm.

• "There is no disease that Allah has created, except that He also has created its remedy" [8]. This narration and several other Prophetic traditions emphasize the Islamic tradition for research into cures for ailments, thus urging believers to be at the forefront of medical research and the treatment and elimination of diseases.

• If the medical intervention is shown to be effective and safe and strongly correlated with a cure or recovery, Muslim scholars have opined that it is mandatory (wajib) to undertake the treatment.

• Otherwise, the default rule for all forms of treatment is optional (ikhtiyari) and not mandatory (wajib) according to the four schools of thought in Islam (madhhab). A few scholars hold the opinion that seeking treatment is supererogatory (sunnah). Very few scholars opine that it is obligatory (wajib) [9,10]

• If the specialist physician counsels his patient and/or family that the chances of a cure or recovery is virtually nil, then there is clearly no religious rationale for ruling that it is wajib or sunnah to offer or to continue with the said treatment modality.

• Therefore, not beginning or discontinuing the treatment modality (e.g. intubation, ventilation etc) is nothing more than choosing not to operationalise the ikhtiyari ruling. Thus, the physician cannot be penalised according to the laws (ahkam), nor should he/she feel any guilt when choosing not to execute an action which is ikhtiyari.

• Since the preservation of life is a priority of the maqasid al-shari`ah, we should always endeavor our very best to preserve and maintain life.

• When we recognize that a cure or recovery is not a realistic expectation, or the treatment options are an exercise in futility, or the treatment entails extreme measures, we may opt to withdraw or withhold such treatment modalities and should counsel the patient or family accordingly.

• We should ensure our patients continue to enjoy appropriate medical and nursing care, maintaining their fluid and nutritional requirements and provide optimal pain relief.

• We should encourage hospice care of the terminally ill as it is consistent with the teachings of Islam. The palliative care advocates a holistic approach, caring for the physical, psychological, social and spiritual wellbeing.

• We should check with the patient or the immediate relatives about any advanced medical directives that stipulate the patient's choice of medical care or interventions, should clinical circumstances (e.g. coma or dementia) render him incapable of decision making when the need arises.

• Apart from healing the physical aspects, we should manifest our empathy by comforting our patients and encouraging them to beseech healing, patience, perseverance, and mercy from Allah (ﷻ).

• The definition and diagnosis of death, has significant importance and many implications from the medical, legal, ethical and Islamic perspectives.

• Euthanasia is categorically prohibited (haram) in Islam, even though it is increasingly advocated and legal in a few western countries.

• Encourage the practise of Talqin to ensure that our patients' critical and end of life moments are righteous with the remembrance of Allah (ﷻ)

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Ethics

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Bridging the Gap – Views of a Muslim Physician Working in Intensive Care

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Treating a critically ill patient presents a unique challenge to a physician working in the NHS. Added to that, as a Muslim, one is faced with interesting ethical scenarios that test both our innate and learned ability to make "correct" and authentic decisions. So how do we, as Muslim physicians in the current NHS dynamic, arrive at sound and grounded decisions in areas such as end-of-life care, the withdrawal of treatment, and organ donation? Better yet, are we well equipped to deal with the growing complexity surrounding such sensitive issues for ourselves as Muslim physicians and Muslim patients?

Despite the large corpus of work analysing medical bioethics in Western medicine, and a substantial Muslim population in the United Kingdom of 2.8 million (1), there is still little in the way of comprehensive guidance produced for those from a religious background, such as Islam, working in a Western setting. This, however, is changing. With a substantial number of Muslim health professionals involved in various domains and specialties in the NHS workforce, advocacy groups have developed on an unprecedented scale, reflecting the demand for such institutions. Leading the way on this is the British Islamic Medical Association or BIMA, which now has a membership of over 2000 health professionals. Its members commonly seek guidance and clarification on day to day ethical dilemmas faced in the workplace, including, but not limited to; end of life care, euthanasia and organ donation.

As this issue has been identified, Islamic scholarship has also sought to bridge the divide between religious academia and the health profession by engaging Muslim doctors and health professionals in the study of Islamic medical jurispudence – a field commonly known as fiqh.
Islamic scholarship has always had a rich history in the field of medicinal sciences, including notable figures such as ibn Sina (Avicenna) and Razi. As well as the copious medical literature of these historic figures, Muslims transfer guidance primarily from sources such as the Quran and Ahadith (sayings of the Prophet Muhammad). In particular, a book called Kitab at-Tibb (the Chapter of Medicine) contains 58 chapters and 105 ahadith. It is therefore a subject far from alien to the Islamic sciences since the very early years of Islamic thought.

There has now been a concerted movement to close the gap between Islamic scholarship and the medical profession in the UK, with online and face-to-face courses developing advanced curricula in the subject of medical fiqh, such as those run by Al-Balagh Academy, based in Nottingham, but with an international following – Al Balagh recently hosted their first international conference in London earlier this year. This has led to an interface between two movements who both serve large communities, yet have the potential to feed off each other to the benefit of contemporary medical ethics in a diverse setting such as the United Kingdom.

As a lifelong student of both medicine and Islam, I firmly believe this is an area that needs strong development, not just at a superficial level between academics, but at the heart of inculcating Muslim medical students with a sound knowledge base. Muslim physicians can underpin their practice with a firm understanding in what their faith deems appropriate, which in many cases is more lenient and diverse than what is anticipated in the field of end-of-life care, family planning and organ donation. This information can also then be disseminated to the wider Muslim population, who may be devoid of the opportunity of access to such information.

As Mahdi et al.(2) postulated in a recent survey of American physicians, there may be a link between the level of engagement one has with their religion, in this case Islam, and the basis for their medical decision-making. Albeit a small study, and focussing on a rather distant populous, it does highlight an interesting question regarding where we derive our medical decision-making guidance from, and what role religion plays, if any, in something so important such as our profession. If one were to use, for example, a basic set of Islamic shar'i (legal) principles from a Hanafi (major school of Islamic thought) perspective (Table 1) as the basis for much of the decision-making in a hospital or primary care setting, one could argue that this provides quite a simple foundation to underpin how we can both practise medicine and explain to Muslim patients our basis for decision making, within the boundaries and rules set by respective regulatory bodies.

It is generally acknowledged that the field of preventative medicine (Tibb al-wiqa'i) is a superior branch of Islamic medicine since it is primarily concerned with the prevention and preservation of health rather than with cure/ therapeutics – known as Tibb al-ilaj (3). Often, in practice, I have found many Muslim physicians and patients are convinced that Islam has a "do-everything" attitude to the preservation of life in scenarios often encountered in hospital medicine, especially in a critical care unit. Yet ironically, few have had any formal Islamic education in the field of fiqh or medicine. This has had, I believe, detrimental effects to fields such as palliative medicine, blood and organ donation, and, more worryingly, the perception and interface between non-Muslim healthcare professionals and Muslim patients and their relatives.

Undoubtedly, the Quran is explicit in its statements underpinning the sanctity and preservation of life; "And whoever saves one – it is as if he had saved mankind entirely – Surah 5:32) yet in the current climate of healthcare, whereby the Royal College of Physicians is debating with its membership whether active euthanasia is to be considered as a viable option in palliative care for example (4), these matters must be addressed from an informed and knowledgeable workforce.

As a trainee in Anaesthesia and Critical Care, how does this translate to working in a critical care unit on a day-to-day basis as a Muslim? In the context of a highly diverse community in the UK, both in the population served and the clinicians who serve, one must first abide by national regulatory bodies such as the General Medical Council (GMC) and often adhere to guidelines, from a national level such as those from NICE, to local and departmental strategies. These often run in unison with many Islamic Shar'i principles, such as the endeavour to preserve life and serve society as a whole, fairly. With limited resources in Intensive Care, one often has to make judgments as to which patients are suitable for both admission and advanced forms of treatment to give a fair and just opportunity to the wider patient population. This can be challenging at the best of times and nigh on impossible at the hardest.

From a personal perspective, I seek support and guidance from those with greater knowledge in both the medical field and Islamic sciences. Having a sound knowledge of medical ethics and Intensive Care medicine is essential to give credence to making appropriate decisions to maintain congruity with the environment within which we work. Indeed, I find that Islamic shar'i principles and guidance learnt through the study of Fiqh and Usul-al-Fiqh help solidify my decision making and make me content and at ease with my practice.

I find an apt analogy of an approach to critical care is that of Ibn Ahmad al-Ayni (d.855), a classical scholar and analyst, who asserted that the field of Tibb al –ilaj, or therapeutic medicine, was motivated by the desire to support the body to retain its natural healthy state, analogous to the "premorbid" state oft-quoted in health settings (5) . It is this notion that describes the supportive and restorative component that intensive care medicine offers. In essence, intensive organ "support" treatments are merely temporising measures to ensure actual treatment of underlying conditions, to help patients regain their health during periods of critical illness. This has helped contextualise treatments when discussing with both Muslim and non-Muslim patients and their families.

It is often a difficult decision to withdraw treatment from a patient, regardless of their religious background; by and large these decisions are made in a multi-disciplinary setting (including patients' relatives) and with some evidence base. Often patients come with unrealistic expectations of what intensive care units can offer in the treatment of patients. Anecdotally, there have been several occasions whereby clinicians have felt intimidated by the passion and sheer number of relatives of patients from Muslim backgrounds. However, I believe that a responsibility we must convey to both junior and senior Muslim clinicians is to be assertive with themselves in what their religion advocates, just as much as they are with what their local and national regulatory bodies do. This, I believe, is the key to the Muslim workforce flourishing in areas such as the treatment of critically ill and dying patients, as well as educating our community at large, including our fellow clinicians.

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Table 1 – Principles of Shari' obligations in seeking medical treatment, adapted from Withdrawal of Treatment and Brain Death: Advanced Cases, Dr Shaykh Rafaqat Rashid, Al Balagh Academy, 2017.

Value		Example	Hukm (Ruling)
Mutayaqqin	Certainty of cure or recovery	Nutrition and hydration	Sinful if such means not taken
Maznun	Probable/expected >50% chance	Most evidence based medical treatment	Not sinful, potentially rewarding if taken with intention of being the Sunnah (way) of the Prophet Muhammad – peace be upon him
Mawhum	Imagined/illusive <50% chance	Therapies with little/no evidence base to their effectiveness i.e. some herbal/home therapy	Permissible. Better to rely on the will of Allah

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History

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The Significant Influence and Contributions of Al-Razi (Rhazes) to the Establishment of Pharmacy During the Middle Ages

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Summary

Al Razi was a Hakim, an alchemist and a philosopher. In Medicine, his contributions were so significant that they can only be compared to those of Ibn Sina. His everlasting fame stemmed from his works in Medicine documented in a number of books, including; Kitab al- Mansoori, Al-Hawi, Kitab al-Mulooki and Kitab al-Judari wa al-Hasabah. Al-Razi was also the first in Islam to write a book based on home medical (remedial) advisor entitled Man la Yahduruhu Teb for the general public. In his book Mnafi' al-Aghthiyyah, Al-Razi further developed a pattern earlier introduced by Claudius Galenus (Galen) and attempted to correct several established errors. Within this field, Al-Razi was one of the few pharmacists who added valuable contributions to Medicine and Pharmacy in the Middle Ages while most of Europe was still living in the dark ages.

The development of professional Pharmacy, as a separate entity from Medicine, started in Islam under the patronage of the early' Abbasiyyah caliphs in Baghdad. This first clear-cut separation of the two professions and the recognition of the independent, academically oriented status of professional Pharmacy materialized in the Abbasiyyah capital (Baghdad) establishing the worlds of Pharmacy and Medicine we know today.

The established field of Pharmacy or Arabic Pharmacy (Saydalah) as a profession with a separate entity from Medicine was recognized by the ninth century. This century not only saw the founding and an increase in the number of privately owned Pharmacy shops in Baghdad and its vicinity, but in other Muslim cities too. Many of the pharmacists who managed them were skilled in the apothecary's art and quite knowledgeable in the compounding, storing, and preservation of drugs. State-sponsored hospitals also had their own dispensaries attached to manufacturing laboratories where syrups, electuaries, ointments, and other pharmaceutical preparations were prepared on a relatively large scale. The pharmacists and their shops were periodically inspected by a government appointed official (al-Muhtasib), and his aides. These officials were to check for accuracy, weights, measures and purity of the drugs used. Such supervision was intended to prevent the use of deteriorating compounded drugs and syrups, and to safeguard the public.

This early rise and development of professional Pharmacy in Islam (over four centuries before such development took place in Europe) was the result of three major occurrences; 1- the great increase in the demand for drugs and their availability on the market; 2- professional maturity; and 3- the outgrowth of intellectual responsibility by qualified pharmacists.

In this study, a number of aspects of Al-Razi's influence on the development of Pharmacy and medical therapy in the ninth century are briefly discussed.

Abu Bakr Mohammad Ibn Zakariya Al-Razi (864-930 C.E.) was born in Ray, Iran. He initially found his interests in to lie in music till his 30s until he began studying Medicine, mathematics, astronomy, chemistry, Pharmacy and philosophy. At an early age he soon gained eminence as an expert in Medicine and alchemy, such that patients and students flocked to him from distant parts of Asia.

He was first placed in-charge of the first Royal Hospital at Ray, from where he soon moved to a similar position in Baghdad where he remained the head of its famous Muqtadari Hospital for along time. He moved from time to time to various cities, especially between Ray and Baghdad, but finally returned to Ray, where he died around 930 C.E. During his time, he produced over 200 publications, with over half of them in Medicine. Distinguished and respected, Al Razi is known as one of the greatest physicians of the Middle Ages. In honour of his works, his name is commemorated in the Razi Institute near Tehran.

Al- Razi was a Hakim, an alchemist and a philosopher. In Medicine, his contribution was so significant that it can only be compared to that of Ibn Sina. Some of his works in Medicine e.g. Kitab al- Mansoori, Al-Hawi, Kitab al-Mulooki and Kitab al-Judari wa al- Hasabah earned everlasting fame.

Kitab al-Mansoori, which was translated into Latin in the 15th century by Gherardo da Cremona under the title Liber medicinalis ad almansorem or Liber Almansorius in short.. Kitab al –Mansoori comprised of ten volumes and dealt exhaustively with Greco-Arab Medicine. Some of its volumes were later published separately in Europe. The contents of the ten volumes was both practical and theoretical, as organised in the following format; chapter one to six dealt with one's diet, anatomy, hygiene, general pathology, surgery and physiology which were all mainly regarded as theoretical. The remaining four chapters of the treatise were devoted to more practical elements of Medicine including diagnosis, special pathology, therapy, toxicology, theriacs and practical surgery. The elaborate and detailed descriptions offered led to much of the book's fame.

His book al-Judari wal Hasabah was the first treatise on smallpox and chicken-pox, and is largely based on Al-Razi's original contribution: It was translated into various European languages. Through this treatise he became the first to draw clear comparisons between smallpox and chicken-pox.

His book Al-Hawi was the largest medical encyclopaedia composed by then and contained important information on each medical subject collated from Greek and Arab sources. Its published version consisted of 23 volumes with two of the volumes further divided into two lengthy parts displaying the enormity of his work. Each volume then dealt with specific diseases or parts of the body. He then concluded by providing his own remarks based on his experience and views. A special feature of his medical system was that he greatly favoured cure through correct and regulated food. This was combined with his emphasis on the influence of psychological factors on health. He also tried proposed remedies first on animals in order to evaluate their effects and side effects. In addition, he was also an expert surgeon and the first to use opium for anaesthesia.

The best survey of Al-Razi's works from the medieval period seems to be an epistle by al-Biruni written about 1037. Through this epistle, concealed sides of Al-Razi's life and his contributions as a prolific author and compiler to Pharmacy and medical therapy can be seen. To understand and appreciate him fully, however, one should view him as the product of his time in the context of his era. Futher evidence of his significance can be noted through renowned historian Will Durant's observation of Al Razi's book, Al-Hawi as one of the nine volumes constituting the whole library of Paris Faculty of Medicine in 1395. (Age of Faith, history of medieval civilization 325-1300, by Will Durant, 1950, page 247)

It was Al-Razi who wrote a book, Shukuk 'ala Nazariyyat jalinus, in which he doubted the accuracy in many medical, physiological and therapeutic concepts, theories, and procedures as stated by Claudius Galenus (Galen). These were blindly accepted and transmitted by his followers and later compilers and commentators. For in the West and Byzantium this was "an age of faith", important to our discussion here, therefore, is his courageous attack of errors in the medical and philosophical teachings of the ancients.

On the professional level, Al-Razi introduced many useful, progressive, medical and psychological ideas. He also attacked charlatans and fake doctors who roamed the cities and the countryside selling their nostrums and 'cures'. At the same time, he warned that even highly educated doctors did not have the answers for all medical problems and could not cure all sicknesses or heal every disease. Al-Razi then exhorted practitioners to keep up with advanced knowledge by continually studying medical books and expose themselves to new information. He further classified diseases into three categories: those which are curable; those that can be cured; and those which are incurable. On the latter, he cited advanced cases of cancer and leprosy which if not cured; the doctor should not take blame.

Al-Razi was the first in Islam to write a book based on home medical (remedial) advisor entitled Man la Yahduruhu Teb for the general public. He dedicated it to the poor, the travellers, and the ordinary citizens who could consult it for treatment of common ailments when the doctor was not available. This book, of course, is of special interest to the history of Pharmacy since books on the same theme continued to appear and has found acceptance by readers to the present century. In its 36 chapters, Al-Razi described diets and drugs that can be found practically every where in apothecary shops, the market place, in well-equipped kitchens, and in military camps. Thus, any intelligent mature person can follow its instructions and prepare the

right recipes for good results. Some of the illnesses treated are headaches, colds, coughing, melancholy, and diseases of the eye, ear, and stomach. In a feverish headache, for example, he prescribed, 'two parts of the duhn (oily extract) of rose, to be mixed with part of vinegar, in which a piece of linen cloth is dipped and compressed on the forehead'. For a laxative, he recommended 'seven drams of dried violet flowers with twenty pears, macerated and mixed well, then strained. To the filtrate, twenty drams of sugar is added for a draft'. In cases of melancholy, he invariably recommended prescriptions including either poppies or their juices (opium) or clover dodder (Curcuma epithymum Muss.) or both. For an eye remedy, he recommended myrrh, saffron, and frankincense, two drams each to be mixed with one dram of yellow arsenic and made into tablets. When used each tablet was to be dissolved in a sufficient quantity of coriander water and used as eye drops.

Al-Razi followed the same method in his book Bur as-Sa'ah, in which he prescribed remedies to cure ailments in one hour, or at least in a short time, so that the patient did not need to frequently call their doctor and pay larger fee.

In his other book on diets, their uses and disadvantages, Mnafi' al-Aghthiyyah, Al-Razi followed a pattern that had been introduced earlier by Galen. In it, Al-Razi attempted to correct several errors made by Galen and to introduce new data missed by the latter.

Ibn Masawayh was another physician who wrote on the same topic. According to Al-Razi, Ibn Masawayh did more harm than good in his exposition of the subject. These misgivings challenged Al-Razi to undertake the writing of a comprehensive study, Mnafi' al-Aghthiyyah which is of great interest not only to Pharmacy and Medicine but to the history of the culinary art as well. Emphasizing specific matters and general regulations for healthy living, Al-Razi discussed breads, waters, dairy products, fruits, vegetables, spices, meats, and fishes. He explained in detail their kinds, methods of preparation, physical properties, and therapeutic modes of action, and pointed out when they were useful and when not. He described the disadvantages of frequent consumption of wines leading to alcoholism, 'which often causes many serious diseases as epilepsy, paralysis, senile tremor in older people, cirrhosis, hepatitis, mental disorders, visionary distortions, obesity, debility, and impotence.

While Al-Razi paid much attention to curing the body's ills, he did not ignore cures for infirmities of the soul. The proof of his concern for psychotherapy seems quite evident. On completing his medical encyclopaedia, al-Mansuri, on the diagnoses and treatment of body diseases, he filled in the gap by writing a counterpart at- Tibb ar-Ruhani on the Medicine of the soul. His concern for, and penetration into, human nature, its complexities, and the directions leading into it, confirm his appreciation of the importance of psychotherapy and psychology as two important parts of the healing art.

In his famous al-Mansuri, however, Al-Razi devoted four out of the book's total of ten treatises, to diets and drugs, medicated cosmetics, toxicology and antidotes, amelioration of laxatives, and compounded remedies, all of which are of pharmaceutical interest.

Al-Razi's last and largest medical encyclopaedia is his al-Hawi fit-Tibb, which embraces all areas of medical knowledge of the time. It included sections related to 'Pharmacy in the healing art', materials arranged in alphabetical order, compounded drugs, pharmaceutical dosage forms and toxicology. It also included numerous medical recipes and tested prescriptions that influenced 'medical therapy' in Islam and in the West during the Middle Ages.

In his use of mineral drugs as external and internal remedies, including vitriols, copper, mercuric and arsenic salts, sal ammoniac, gold scoria, chalk, clay (as in the terra sigillata and Armenian clay), coral, pearl, tar, and bitumen, Al-Razi, encouraged and pioneered chemotherapy in Islamic Medicine. Although he recommended poppies and opium internally as somniferous agents and to quiet coughing, and externally to relieve eye and wound pains, he warned against their deadly effects (two drams are fatal).

Conclusion

The development of professional Pharmacy, as a separate entity from Medicine, started in Islam under the patronage of the early' Abbasiyyah caliphs in Baghdad. This first clear-cut separation of the two professions and the recognition of the independent, academically oriented status of professional Pharmacy materialized in the Abbasiyyah capital (Baghdad). With Al-Razi being one of the few pharmacists who added very valuable contributions to Pharmacy and Medicine at the time, he ultimately propelled the field in the Middle East whilst most of Europe were centuries behind in their practices!

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Advocacy

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A Survey - Do Trusts have Guidelines on Headscarves in Theatre in their Uniform Policies?

Abstract of poster which was presented at the BIMA National Conference, Birmingham 7th December 2019

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Dress code may be a source of anxiety for some Muslim female healthcare professionals working in surgical theatres. In a survey conducted by the British Islamic Medical Association (BIMA) 50% of respondents had experienced problems wearing a headscarf in theatre, with over 30% reporting avoiding theatre attendance as a result and over 12% claiming the issue had impacted their career choice. Although there is no national policy addressing this, the 2010 Department of Health Uniform and Workwear Guidance does say 'As far as possible, subject to the overriding requirements of patient safety and public confidence, staff should feel comfortable in their uniforms. This includes being able to dress in accordance with their cultural practices'. This survey investigates how many trusts made specific mention of policy regarding headscarf in theatre.

33 uniform policies were collected utilising 2 methods – an internet search engine to locate publicly available policies and the use of British Islamic Medical Association networks to improve coverage. They were then analysed to see if the uniform policy specifically mentioned headscarf in theatre.

Only 4 policies (11.8%) made mention of headscarves in theatre. Of these one said 'use of headscarves is not permitted in theatre areas' without stating an alternative; one suggested people could bring in their own, freshly washed navy blue or black headscarf; one suggested that headscarves must be completely covered with 'protective headwear' and one said headscarves must not be worn if the person is scrubbed but an 'orthopaedic hood' would be available if requested.

This suggests that there needs to be further work to encourage trusts to provide clear policy on headscarves in theatre. There appears to be significant variation in guidance provided by the four trusts in our survey without reference to an evidence base.

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An Audit of Whether Hospital Trusts are Providing an Alternative to 'Bare Below Elbows' for Muslim Female Healthcare Professionals

Abstract of poster which was presented at the BIMA National Conference, Birmingham 7th December 2019

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Since 2007 all NHS healthcare professionals must perform clinical duties 'Bare Below the Elbows' (BBE). This causes difficulty for some Muslim female healthcare professionals who feel it is inconsistent with Islamic guidance on dress code. The Department of Health revised its guidance in 2010 to account for 'cultural issues associated with workwear'. This included suggestions such as uniforms to have three quarter length sleeves, full length sleeves when staff are not engaged in direct patient care activity or disposable over-sleeves. Suggestions were summarised in Appendix B of the guidance. This audit measures how many trusts are incorporating this revised guidance into their uniform policy.

33 uniform policies were collected utilising 2 methods – an internet search engine to locate publicly available policies and the use of British Islamic Medical Association networks to improve coverage. They were then analysed using the criterion 'Does the uniform policy incorporate recommendations from Appendix B of Department of Health's Uniform and workwear guidance?' An internal standard was set at 90%.

Of the 33 policies reviewed, only 9 stated alternatives to BBE should be provided (27%) and of these, only 7 trusts said disposable sleeves could be provided by the hospital.

The majority of trusts have not incorporated the revised guidance on BBE into their uniform policies leaving them open to scrutiny. Greater awareness is required of this issue and trusts need to be encouraged to revise policies in line with the 2010 Department of Health guidance.

BIMA has also produced toolkits to educate Muslim female healthcare professionals at the grassroots level with the knowledge and resources needed to approach infection prevention teams and request amendments to policies if necessary. We intend to re-audit to assess the impact of our toolkits in 3 year's time.

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'Bare Below Elbows' Policy: A Barrier To Female Career Progression?

Abstract of poster which was presented at the BIMA National Conference, Birmingham 7th December 2019

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Practising Muslim women who wish to observe faith dress codes face unique challenges whilst working within the healthcare sector. NHS dress code policies such as 'Bare Below the Elbow' policy (BBE) may run contrary to normative Islamic dress code (intended to cover the whole body besides the hands and face). Despite national Department of Health Uniforms and Workwear policy offering alternative options, local implementation has been suggested to act as a barrier to career progression. This study explores the views of Muslim women on dress codes while working in the NHS.

Methods: A quantitative, self-completion cross-sectional survey was distributed at the 'Muslim Women Excelling in Islam and Medicine' conference organised by the British Islamic Medical Association (BIMA) in Spring 2016.

Results: Out of 84 responses (median age 27 years, range 18-56) it was found that 83% usually covered their forearms for religious reasons and that three quarters reported that it was 'important to them' due to religious beliefs. Many (84%) reported being BBE whilst in hospital or working on wards. However, few (7%) reported their Trust had suggested an alternative in light of their religious beliefs (such as using disposable sleeves). It was found that less than half (44%) felt their faith requirements were acknowledged by the Trust with a notable 16% indicating their experience of the BBE policy had influenced their career choices.

Conclusions: This study demonstrates the dress code challenges that female Muslims face when working in the NHS. Greater clarity around equality and diversity considerations is required regarding BBE policy. This is one illustration of a wider issue of how policies can be at odds with personal beliefs that may contribute to reducing workforce diversity.

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Advocacy

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Experiences of Female Muslim Healthcare Professionals Wearing Headscarves in Theatres

Abstract of poster which was presented at the BIMA National Conference, Birmingham 7th December 2019

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Introduction: There is currently no national policy on flexible workwear in surgical theatres for those with protected characteristics and few trusts that address this issue locally. Ali and Bowbrick (2014) suggest this may be a barrier to career progression for Muslim women at all stages of training. This study, for the first time, formally explores the experiences of Muslim women working within the theatre environment. A potential solution that meets both infection prevention and faith requirements is also presented.

Methods: A quantitative, self-completion cross-sectional survey was distributed at the 'Muslim Women Excelling in Islam and Medicine' conference organised by the British Medical Association (BIMA) in Spring 2016.

Results: Eight four questionnaires were returned from respondents with a mix of seniority and speciality. The majority of respondents reported wearing the headscarf (94%) and cited this was considered important to their religious beliefs. Despite 91% reporting their religious requirements were respected by the theatre manager, 55% felt their religious requirements were met by local policy and were happy with the policy. 52% had experienced problems when trying to wear a headscarf with 32% reporting avoiding theatre because of concerns e.g embarrassment (23%) anxiety (37%) or bullying (37%); 14% indicated this had an impact on their career choice.

The survey also assessed the feasibility of a prototype 'single use disposable theatre hijab' that aimed to cover the head and neck. 99% agreed that this was a feasible option.

Conclusions: Trust uniform policies need provide more detailed guidance in order to meet legal, faith and infection prevention requirements in theatres. Muslim female healthcare workers must be encouraged to report to their Trusts when feeling marginalised. Trusts should be encouraged to review theatre dress code policies and develop feasible solutions. A disposable theatre garment innovated by this research team could be a workable alternative.

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A Beginner's Guide to the Concept of Islamic Psychology

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Keywords: *Islam, Psychology, Islamic Psychology*

Background

The concept of Psychology, viewed in a clinical format, tends to present itself in the Western world as an objective universal science. The term 'Western Psychology' and its derivative therapies are however fundamentally rooted in western value systems, western paradigms of thought, and empirical studies mostly undertaken within 'Western' population samples (1,2).

Western Psychology and therapies are consequently 'culture bound' – its application cannot truly be claimed universal and has an uncertain relevance to those from non-western cultures, and to cultural sub-groups within the 'West', and even to 'Western' societies as the concept shifts culturally with time (3).

Beyond the western world, other cultures, usually from a much earlier starting point, have developed their own traditions of Psychology. These are described by Enriquez as 'indigenous psychologies from within' (2).

In Islamic civilisation, writings on Psychology, both in its theory and its clinical applications, begin early, - probably with Al-Kindi(801–873 CE), followed by Al-Balkhi, Al-Ghazali, and Ibn Arabi amongst others (4,5). All of these based their understanding of human psychology on Quranic sources and incorporated other sources as appropriate. The author was told that ʿIlm al-Nafs (academic psychology) was on the syllabus at Nishapur University by the 14th century C.E., and Ṭibb al-Nafs (Clinical Psychology/Psychiatry) by the 15th century C.E. Certainly by the late 14th century C.E. when the Ottoman mental hospital at Edirne was established, there was a developed understanding of mental disorders and of how they could be effectively treated.

There seems to have been a hiatus in the development of psychology from an Islamic tradition after the late medieval period. Arguably this was because what had already been developed, and practised by Hakims and others, was sufficient for a stable fiṭri based society, until Western Psychology began to significantly intrude into the Muslim world in the 1970s. This intrusion produced a reaction from Malik Badri, a British trained Clinical Psychologist, that resulted in the publication in 1979 of The Dilemma of Muslim Psychologists (1,6). In this work, Badri argued that Western Psychology contained elements antagonistic to Islamic precepts which, if not challenged, would result in (to use Enriquez's term) a 'colonisation of the mind'. Since then, there has been a growing international interest in developing an Islamically based psychology, and psychological therapies that are fitted to the increasing complex psychological problems of the modern age.

In the U.K., Abdullah Maynard and SabnumDharamsi began teaching a 'mainstream' accredited course in Islamic Counselling some 25 years ago. For the last 10 years, courses aimed at orientating existing clinicians to Islamic models have been taught at the Cambridge Muslim College and elsewhere in England. Some five years ago, Ihsaan and Inayat, consortia of Islamic psychological therapists, were established in West Yorkshire and Lancashire respectively. In 2017, Malik Badri established the International Association of Islamic Psychology to protect the integrity of the field, and to accredit therapists and training courses.

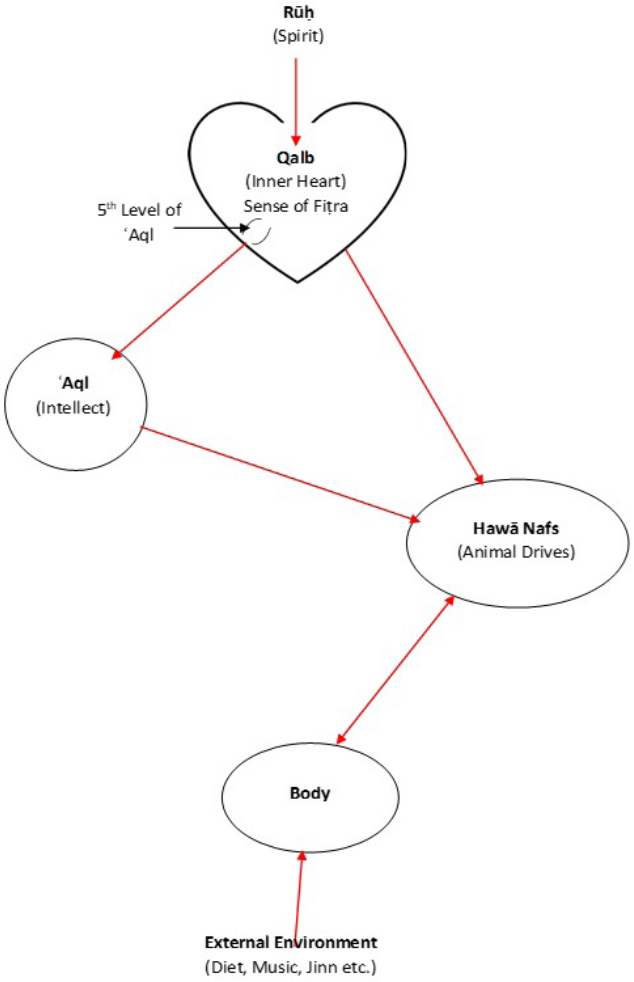
Defining Islamic Psychology

The International Association of Islamic Psychology defines Islamic Psychology as the Psychology that is based on an Islamic paradigm. Paradigm, from the Greek, being understood as an underlying foundational motif. Abdallah Rothman (7,8) has defined what constitutes an Islamic paradigm in psychology, and this definition has met with widespread acceptance.

Standing on this paradigm orientates the clinician in understanding pathology and its treatments, as well as indicating the conduct (adab) appropriate to the therapeutic relationship, and it establishes a standpoint from which to critique Western and other psychologies. The Psychology that derives from an Islamic paradigm is fundamentally distinct from culturally adapted or 'Islamicized' Western Psychology, and is a completely different field from 'Islam and Mental Health' (9).

An Islamic Model of the Self

Fig. 1. An Islamic Model of the Self (8)



The model, exampled here, was first presented by the author as part of his paper to the IIIT London conference in 1989. It was devised after discussion with Islamic scholars available at the time in England, (in particular Shaykh Zahran Ibrahimand Muhtar Holland); and practicing clinicians including Alia Haeri and Hakim Salim Khan. The aim was to produce a simple diagrammatic model that would assist the clinician in makingdiagnoses and treatment decisions. It does not pretend to capture the full complexity and subtlety of Man's nature. It is the model adopted by Ihsaan, the Bradford based Islamic Psychological therapy clinic, and is taught at the Cambridge Muslim College, and has been found acceptable to Islamic therapists over the last 30 years. It is not however the only model. Abdullah Rothmanhas published a diagrammatic model slightly different (10); and there are other authentic models. It is up to the therapist to decide which best assists their clinical practice.

Key Concepts

Quranic Arabic terms have a depth of meaning and nuance and have often been understood in different ways by classical scholars. The terms used in this here take an aspect of meaning which makes sense of psychological phenomenon, - broadly following the usage of Al-Ghazali (11).

Qalb: A distinguishing feature of Islamic Psychology is that it acknowledges a spiritual centre at the centre of the human being. Western Psychology, in the main, ignores or denies such a centre, - the main exception being the marginalised Psychology of Carl Jung. Some traditional scholars term the inner centre as ʿAql (see below), or Rūḥ (spirit), but Al-Ghazali mostly uses the term Qalb (heart). The Qalb is perceived as containing an inherent sense of 'fiṭra' – what is natural and right, – and is open to divine inspiration (Rūḥ) – in the form of true dreams and inspired intuition for example. Generally speaking, the Eastern religions such as Buddhism do not conceptualise the inner self as open to divine inspiration: - or at least, not in the same way as do the Prophetic religions.

ʿAql: ʿAql can be translated as intellect, or the cognitive faculty. Al-Ghazali describesʿAql as having five functions. Four of these essentially describe the intellectual operations, such as logical reasoning, understood in Western cognitive psychology. The fifth function, however, is of a different level and can be considered as being part of and extending from the Qalb. This level of ʿAql is that which receives and articulates the knowledge of the heart (gnosis). It is this aspect of ʿAql which should direct the operations of the other parts, to avoid reasoning becoming disassociated from fiṭra and becoming (to paraphrase a Ḥadith) like 'sorcery'.

The root meaning of the word ʿAql' is shackle. Aql is normally understood as the faculty that shackles, or reins in, the forces in the Hawā. However, ʿAql (in its outer four functions) can also be seen to sometimes shackle the Qalb, - constricting the flow of gnosis coming from that source. When this happens, a transitory psychotic like state, or spiritual crisis, can occur as the 'shackle' is temporarily broken to allow new knowledge to be received. Jung describes experiencing such a state during the First World War period (12).

Hawā: 'The animal self' refers to the instinctive drives and energies we require for our existence in this life. Colloquially, (even in Al-Ghazali's day) these drivesare often referred to as 'the nafs'. Particularly in the Islamic medical tradition, (Ṭibb), there is an understanding that the balance and type of these energies are closely related to diet.

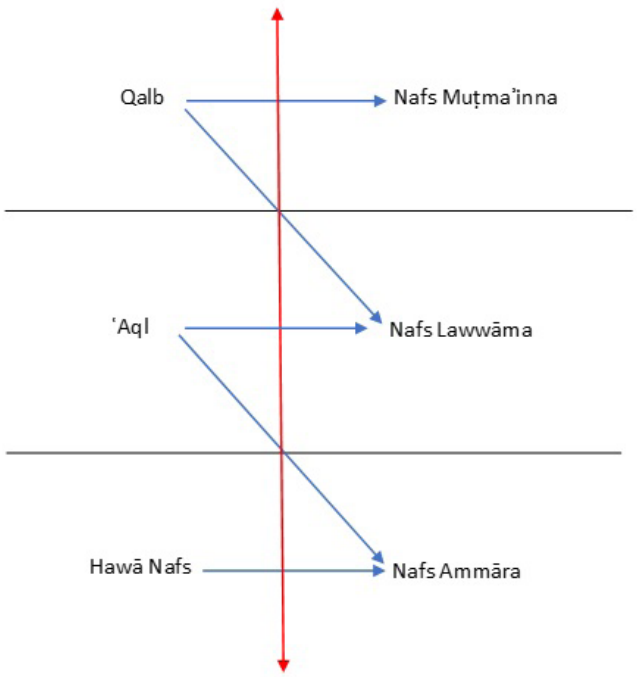
The Body: In part, the body can be viewed as the base layer of the Self; - the carnal casing, necessary for this life but discarded at death. It is the vehicle for carrying out the instruction of the internal faculties (of the Qalb, ʿAql, and Hawā), and is the entree point for environmental forces (from food and drink, the atmosphere, mobile phones,

jinn etc.) which then alchemise into internal energies, - particularly within the Hawā.

However, Islam is an embodied religion: for example, in the physical movements of the ritual prayer (ṣalāt); and the Prophet (peace be upon him) emphasised the spiritual significance of the 'sunna sports', - archery in particular. In one hadith, likening archery to a form of prayer (ḏikr). There is thus an understanding that the body has a subtle relationship with the Qalb and spiritual state.

Ibn ʿArabi is one scholar who deals with this aspect of the body (13). Taking the hadith relating how our body parts will bear witness, for or against us, on the Day of Judgement, Ibn ʿArabi conceives the body parts as having their own semi-autonomous existence, - their own ḏikr, and their own wish to worship God through the Human Being. This understanding underlies Islamic traditions of working with the body to remedy imbalances in mental or spiritual states and gives a perspective on 'psycho-somatic' symptomatology.

Fig. 2. Levels of States of Being (8)



Dynamics: Ḥadith relate that each child is born in'fiṭra', - that is, in a pure natural state absorbed in the awareness of God. Immediately after birth, however, the baby is pricked by Shayṭān.Thus, in this life, the Self is conceived as containing a continual struggle between the pull of fiṭra emanating from the Qalb, which seeks to bring the Self back to what is natural and right for the human being, and back into union with God; and the pull of Shayṭān in the opposite direction.

The three levels, or states, of the Self described in the Quran (Q. 12:53, 75:2, 89:27-28),Nafs Ammāra, Nafs Lawwāma, Nafs Muṭmaʾinna, can be seen as reflecting the outcome of this struggle at any point of time. Nafs Ammāra (the Compelling Self) thus refers to the state of the Self when it is dominated (compelled) by the lower energies of the Hawā. Nafs Muṭmaʾinna (the Well Pleasing, Contented Self), the state when the Self is under the direction of the Qalb. Nafs Lawwāma (the Remorseful Self) is the bridging state, in which the Self has awareness of its separation from fiṭra and closeness to the divine. The state of Nafs Lawwāma is critical for psychological work, as in that state, the individual can either resolve its pain by seeking the remedy that brings it back to completion and contentment; or can dissociate from the pain (through, for instance, certain types of defence mechanisms) and descend back into Nafs Ammāra.

Definition of Mental Health

In the author's perception, Western Psychology generally gives little consideration to defining mental health (Jung is an exception, and in his way, Freud). Islamic Psychology does have a fairly clear conception. Mental Health can be defined, in terms of the model, as that state in which the Self is under the full control of the Qalb which is open to divine inspiration. In effect, this is the same as the Self being in full alignment with the Fiṭra, and being, at least able to access the state of Nafs Muṭmaʾinna.

Al-Ghazali (14) gives the analogy of the rider on a horse. In this analogy, the horse is the Hawā, healthy and operating in its fiṭra; guided by ʿAql (the reins), under the control of the rider who is centred in the Qalb under divine guidance. From this analogy, psycho-pathology can be seen in different manifestations. For example, the horse out of control; the horse under control but by the reins directing it in an irrational way;the horse firmly under control and being firmly guided by the reins to where the rider wants to go but being contrary to fiṭra and destructive.

Diagnosis

The suggested model of the Self (Fig. 1) and understanding of the dynamics operating within the Self (Fig. 2), and the Islamic definition of mental health are all guides to diagnosing pathology. Though a dysfunctionality in one level of the Self is likely to radiate through the other levels, the therapist should have an eye to where the epi-centre of pathology lies, bearing in mind the pathology of the Qalb and the disconnectedness of the body; as well as the interplay between ʿAql and Hawā, which is the almost exclusive focus of mainstream Western Psychology.

Of particular importance, is recognising the difference between low mood associated with a state of remorse (nafslawwāma), - (which is a healthy stage of transition to self-completion and well-being), from low mood as a symptom of pathological depression.

There are two further Islamically distinctive considerations in diagnosis. One, is clarifying whether a person's problems are resulting from being dissociated from fiṭra, - essentially a pathology of the Qalb; or, whether the problem results from the person being in touch with their fiṭra but living in a society which is not.

The second, is to consider the 'primary' as well as the 'secondary' causation of a condition. The primary causation is always God in Islamic thinking, and accepting this leads to a consideration of the meaning of the condition, since nothing is ordained without meaning. The secondary causation refers to the agents that are used to directly cause the condition (e.g. trauma, or inappropriate diet). Al-Ghazali criticised Ibn-Sina for not paying sufficient attention to the primary causation of a disease.

In his Alchemy of Happiness (15), Al-Ghazali gives a good example of the incompleteness in diagnosis that comes from only considering secondary causation. Al-Ghazali describes a man who goes to a physician complaining of feeling low in mood and having lost pleasure in life. The physician diagnoses melancholia and prescribes a medicine. But, says Al-Ghazali, it did not occur to the Doctor that God had so created that state of depression in His servant so that he would return to Him. In other words, the depression (whatever its secondary causes) because it leads to a diminishing of interest in the outer world, facilitates a reconnection with inward spirituality.

Therapy

The goal in Islamic therapy is to bring the client back to a state in which they are connected to their Qalb (heart), in which state the client can access their own internal guidance. Or, at least, the therapist should aim to remove obstacles to achieving that state, and avoiding putting obstacles in the way. This understanding relates to the goals of Jungian Psychotherapy.

The author knows of three studies (16,17) which researched what factors Muslim Psychotherapists regarded as the most important variables in healing. All three studies found that it was the inner state of the therapist that was regarded as the most important factor. If the therapist is in touch with their heart, this seems to facilitate the client reaching the same state.

Beyond this, any therapy from whichever tradition, that does not conflict with the Islamic paradigm can be used. As the hadith states, "all knowledge is the property of the Believer". However, caution needs to be exercised with any therapy that derives from Freud. As Badri articulated in his 1979 publication (6) Freud's psycho-analytic theory can be toxic for Muslims, (which is not to say some of Freud's clinical observations do not have validity). Caution also needs to be exercised with the mindfulness techniques derived from Buddhism to avoid a state in which mind controls mind to the point that a dissociation is produced, both from the Qalb and from outer life. There are, however, Islamically sound practices of 'contemplation' which are entirely sound (4) and which open up the heart.

It is worth noting that caution needs to be exercised with techniques, such as N.L.P., which strongly strengthens the 'will' as the effect of such techniques can make it more difficult to be in a state of submission to the Qalb. In moderate doses with some conditions, such techniques can be useful; - but with regard to what Ibn Sina said, - that a skilled physician can use a poison if all else fails providing he is careful with the dose.

As Islamic Psychology pays attention to the inner spiritual part of the Self, and to the subtle relationship of the body with spiritual and mental states, a holistic Islamic Psychological therapyshould also be able to access various therapies that includes Quran recitation, Ṭibb, Ḥijāma (cupping), the sunnasports; and traditionally, music, scent, colour and architecture. In the West, these are not normally regarded as part of the psycho-therapeutic repertoire.

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The Role of Muslim Chaplains in Health Care

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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.

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Raising Awareness about Organ Donation in the Muslim Community - a Pilot Project

Abstract of poster which was presented at the BIMA National Conference, Birmingham 7th December 2019

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Introduction: Black, Asian and Minority Ethnic (BAME) groups represent 11% of the UK population but a disproportionate 35% of those waiting on the transplant list (1). 21% of those who died waiting for an organ last year were from BAME background. The statistics suggest that there are not enough donors from the BAME population hence disproportionately high proportion of BAME population suffer longer or die waiting for an organ.

Methods: In view of upcoming change in law about organ donation (2) the British Islamic Medical Association (BIMA) are organising a national campaign to increase awareness about organ donation among the Muslim population to help people make an informed choice. BIMA started the campaign with the first programme as a pilot project which was organised in Newcastle upon Tyne on the 23rd of June 2019 where we invited Islamic scholars, medical experts as well patients who suffered from organ failure to speak and have an open discussion with members of the community to help them make an informed choice(3).

We used a questionnaire to assess the views of the audience before and after the talks.

Results: A total of 86 people completed the questionnaire. 70 of whom said that they had not registered to be organ donors and only 14 said they were registered organ donors.

Most of the people (50 out of 86) were unsure if organ donation is permissible (halal) in Islam and only 25 of the 86 thought that organ donation is permissible in Islam.

After the programme when the people became more aware by listening to medical experts about the current statistics of organ donation, the process and ethics followed in NHS and the opinion of Islamic scholars 72 out of 86 people came to the conclusion that organ donation is permissible in Islam indicating significant positive shift of 55%.

Only 16% of the people had registered to be organ donors before the event but after the event 79% are convinced and wish to register as organ donors.

Conclusion: Increasing awareness about Organ Donation is a necessity and one of the ways it can addressed is by organising similar awareness programmes in the community. These programmes not only help to educate people about the organ donation process and the ethics followed in the NHS but also helps to make the community aware about the religious opinions of Islamic scholars.

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The Delivery of Cancer Screening Campaigns within Faith Institutions

Abstract of poster which was presented at the BIMA National Conference, Birmingham 7th December 2019

Nasreen Akhtar *Registered General Nurse & Member of BIMA Cancer Screening Campaign*

Background: Cancer screening uptake within ethnic minorities has been well documented to be lower than the national average. This is further emphasised when we look at screening uptake within British Muslim communities. Health inequalities within this this group stem from cultural and religious beliefs marred with language barriers and pockets of social and financial deprivation . A combination of these factors tend to hinder British Muslims from accessing cancer screening services that are available to them.

Islamic faith is seen as a Centrepoint in the lives of many British Muslims therefore utilizing mosques and community faith based centres was deemed suitable to convey our cancer screening campaigns.

Method: Educational content which formed part of a presentation highlighting the 3 national cancer screening services, namely; breast, bowel and cervical cancer was provided by Cancer Research UK (CRUK) . This was reviewed by members of the Cancer Screening Core Review Team to make sure it is tailored to deal with cultural sensitivities.

The Muslim Council of Britain (MCB) helped us facilitate 39 faith based venues up and down the country to deliver the talks. Furthermore 5 local radio stations were also involved in delivering cancer screening awareness talks via their airwaves. A team of 900 BIMA members participated in the delivery of the talks throughout the months of February and March 2019.

Results: The cancer screening talks where a success as 900 individuals attended the events. A total of 166 feedback forms where received in valuable data. Nearly 50% of this number identified their ethnic origins as that of a British South Asian. 26% where unaware of the 3 national cancer screening programmes and 37% had previously missed their invitation to cancer screening. Overall the majority of the feedback received was positive as over 90% said that they would attend screening as well as encouraging others, in comparison to 38% and 53% before attending the talks.

Conclusion: Faith based health promotion has proved successful in this instance as it has triggered positive health awareness behaviours. Moving forward more research is needed to allow conventional health screening campaigns to be delivered in culturally adapted formats within faith institutions. In doing so health inequalities that exist due to language, cultural and religious beliefs can be reduced paving the way for equality in not only cancer screening but all other health related categories.

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The Healthy Ramadan Campaign 2019

Abstract of poster which was presented at the BIMA National Conference, Birmingham 7th December 2019

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Background: In light of the significant attention drawn to the role of Health Promotion by Public Health England's Strategy (published 2019), British Islamic Medical Association (BIMA) has successfully been running campaigns to encourage healthy eating and maintaining health during Ramadan. This is the 3rd year we have done this campaign.

Method: The team has developed Power point Presentations involving a range of medical professionals such as GPs, Consultants, Diabetologists, Dieticians and other allied health professionals. The project aims to increase awareness of healthy eating, maintaining health and wellbeing during Ramadan, manage drug intakes and address issues surrounding medical conditions. The resources have been informed by research from Diabetes UK, International Glaucoma Association and supported by Muslim Council of Britain.

Results: In 2019, 55 mosques and 11 radio stations across the UK have participated in teaching the local community about leading a Healthy Ramadan despite chronic illnesses such as Diabetes. This involved approximately 80 people who have been from a range of healthcare professionals delivering a talk explaining the importance of maintaining good health in Ramadan from a medical perspective and reducing the risk of potential health complications. Professionals have encouraged their local communities, for example the South Asian to visit their GPs and discuss the risks of fasting due to the prevalence of cholesterol-related and diabetes-related diseases.

Although there were no feedback forms filled attendees to the presentation gave very positive feedback about the talk and asked pertinent questions about their health.

Conclusion: We have shown that there is an appetite in the community to improve their over health and to fast during Ramadan safely keeping in line with the principles of their belief. For 2020, the team envisage that the project will expand to many more Mosques, as more professionals from different regions in the UK come onboard with the project.

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The Impact of Ramadan Fasting on Health

Abstract of poster which was presented at the BIMA National Conference, Birmingham 7th December 2019

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Background: Ramadan fasting is one of the five pillars of Islam. The number of studies conducted to explore the impact of Ramadan fasting on health is relatively low compared to the number of Muslims who perform this religious practice every year. Previous studies reported contradictory results about how Ramadan fasting affects health.

Methods: Five clinics in five different mosques in London were set up to collect data twice from worshippers. We collected data from 85 participants (45 men and 40 women, age 45.39 ± 15.89). The first visit was one week before Ramadan and the second visit was during the second week of Shawaal (the month after Ramadan). Collected data included Blood pressure, blood samples and body composition. Also, we asked participants to fill out a three days' food diary before and during Ramadan to monitor change in food intake. Moreover, participants answered a questionnaire about different aspects of their lifestyle such as sleep pattern and smoking before and after Ramadan.

Results: We reported a significant reduction in systolic and diastolic blood pressure with mean differences of 7.30 mm Hg (p-value < 0.001) and 3.42 mm Hg (p-value < 0.001) respectively. Likewise, a significant reduction was noticed in weight (mean difference = 1.60 kg, p-value < 0.001), waist circumference (mean difference= 1.83 cm, p-value= 0.004), hip-circumference (mean difference= 3.05 cm, p-value < 0.001), fat percentage (mean difference = 0.92 kg, p-value= 0.002), fat mass (mean difference= 1.19 kg, p-value < 0.001). There was non-significant reduction in fat free mass (mean difference= 0.50 kg, p-value= 0.15). The rest of data are understudy.

Conclusions: Our study showed that Ramadan fasting is significantly associated with a positive reduction in blood pressure and most of anthropometric measures. However, it is still not clear whether these changes are temporary or permanent.

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Using ACE FY1 Induction Course as an Intervention to Increase Confidence in Newly Graduated Doctors Before Starting Foundation Year 1

Abstract of poster which was presented at the BIMA National Conference, Birmingham 7th December 2019

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Introduction: Transitioning from a final year medical student to a foundation year one doctor can be a stressful experience for many newly graduated doctors due to the uncertainty of the next stage in their careers, exacerbated by the media using phrases such as 'Black Wednesday'. This is detrimental for both the junior doctors themselves and potentially can have an effect on patient expectations. The introduction of the ACE FY1 course aimed to provide support for newly graduated doctors hosted by foundation trainee doctors who had recently gone through the transition process themselves.

Methods: ACE FY1 Induction Course was held at three locations, the largest event was held in London at University College London (UCL) run by volunteering junior doctors in foundation year training and UCL RUMS medical students. The course covered practical matters such as managing finances, provide an opportunity for simulation of an acutely unwell patient and discussion of prioritisation of bleeps, how to be a successful Muslim doctor, and a general Q&A session. Over 60 attendees were present at the course, and a feedback form was linked on the final slide of the presentation delivered at the last session, with a reminder email sent after the event. 50 attendees completed the feedback form. The data was collated using Survey Monkey and interpreted by two of the event organisers.

Results: There was a significant increase in the number of attendees who felt confident and rated themselves above average in confidence after the event. 18% of attendees said they initially felt they had above average confidence prior to the course, compared to 64% of attendees after attending the course.

Conclusion: We found that most of the attendees seem to find the ability to ask questions and interact with the facilitators and junior doctors as the most useful aspect of the course. Another area which attendees seem to find was confidence boosting was the way in which our facilitators had found their own tips and tricks to problems or barriers in the workplace- this allowed discussion as the attendees also appreciated the diversity of the background of the facilitators with positive personal interactions being most important. Another key aspect of the event was that attendees seemed to appreciate was the delivery of the content- i.e. the focussed nature of simulation and the opportunity to practice skills, however they also valued the content itself. An example of this was the theme of Islam itself- attendees appreciated the content and also the encouragement to practice their faith in the workplace. Ultimately we feel that the course was a useful tool in increasing the confidence of newly graduated doctors before starting their FY1as shown in both the quantitative and qualitative data.

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Relief

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Health Care and Ongoing Conflict

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Introduction

The Syrian crisis will soon be entering its tenth year, and its adverse impact on the delivery of health care to civilian populations shows no sign of diminishing. The conflict has seen health care infrastructure being reduced to rubble, and health care staff driven out, detained, or killed. Contributions of medical relief organisations have been pivotal in maintaining some semblance of a health care system in the war-torn country.

Health care under attack

One of the striking and deeply disturbing hallmarks of the ongoing crisis in Syria has been the deliberate and concerted assault on health care facilities by the Syrian Regime and its Russian backers (1,2). These abhorrent attacks started at the very early days of the conflict, in brazen disregard of International Humanitarian Laws, and continue, with complete impunity, to this day - nearly nine years on (3). And while attacks on health care facilities and infrastructure are not new or unique to the Syrian crisis (2,4) , the extent and intensity of these attacks in this conflict have reached levels that vastly exceed anything recorded in any other conflict, previous or current (2).

Early response - Managing war injuries

In the early stages of the conflict, medical relief efforts focused almost entirely on providing immediate response to injuries resulting from military action, such as bullet and shrapnel wounds, blast injuries, crush injuries, burns, and similar conflict-related conditions. A number of Syria-focused relief organisations, like Syria Relief (www.syriarelief.org.uk) and UOSSM (www.uossm.org), as well as several other organisations in and outside the UK, tried desperately to set up, fund, and supply emergency response centres, forward medical points, and trauma centres, and made concerted and impactful efforts to provide training and professional support for medical staff who had little or no previous exposure to war injuries. Both above-mentioned organisations relied heavily on the Syrian health care professionals working in the UK, through professional links with the Syrian British Medical Society (SBMS), in delivering training, professional support, and funding for their fledgling medical relief efforts on the ground.

Widening focus

As the conflict dragged on, and as the systematic degradation of the health care infrastructure continued and escalated, the demand for trauma care continued and, indeed, intensified. At the same time, there was a growing recognition that some resources need to be allocated for the management of chronic conditions and other "normal" illnesses that are not related to the conflict, as facilities providing care for those conditions became increasingly dysfunctional and extremely hard to access.

Relief organisations involved in the delivery of health care on the ground became increasingly aware of the serious shortages of provisions of primary health care, public health, peri-natal care, family planning and chronic illnesses to civilian populations and displaced communities. Organisations like Syria Relief and UOSSM actively sought to address these shortages, by setting up Primary Health Care centres, which acted like large "polyclinics", providing primary and managing long-term chronic illnesses, from diabetes to chronic respiratory and cardiovascular conditions. Funding was secured by canvassing large international NGOs who have been raising funds for Syria. These international NGOs found in such projects, which were implemented by the aforementioned Syrian relief organisations, a useful and legitimate means to utilise the significant sums that they have raised, but were unable to use directly for projects inside the war-torn Country.

Public health concerns

In addition, numerous important programmes were launched, including several mass vaccination programmes to ensure that civilians, especially children, in displaced communities build the necessary immunity to protect these communities from the dangers of rampant outbreaks

of infectious diseases. The crucial importance of such programmes became all too clear with the outbreaks of serious diseases that have not been seen in Syria for decades, including polio, measles, and TB. Importantly, the impact of these high-quality, professionally organised and run programmes was manifestly clear, as they brought those outbreaks under control, thus saving hundreds of thousands of civilians form serious illness or even death.

Mother and baby

The availability of proper and accessible peri-natal care is essential for a healthy pregnancy, healthy delivery, and healthy development of the new-born baby. With the destruction of the health care infrastructure, viable alternatives were in high demand, and the medical relief organisations had to step up their actions. Consequently, utilisation of existing expertise of local midwives, based in newly set-up Primary Health Care centres, were the natural response to the crisis. Subsequently, resources were directed to setting up specialist maternity hospitals, incorporating Special Baby Care Units with incubators, along with the specialist expertise of local obstetricians, paediatricians, midwives and paediatric nurses.

Caring for Body and Mind

It is not difficult to imagine the distressing impact of the ongoing conflict on mental health in affected communities, especially amongst vulnerable sections of these communities, such as children and the elderly.

Efforts to address this immensely important problem started at the very early stages of the conflict, and have continued and developed ever since, with the immense dedication, commitment and sacrifices made by a group of psychiatrists and psychotherapists, through the main relief organisations working on the ground.

Knowledge transfer and capacity building

Effective management of war injuries requires specialist expertise and highly refined skills, and such precious resources were not readily available amongst the relatively inexperienced staff on the ground. Syria Relief, UOSSM, and the SBMS joined forces to organise specialist training courses for health care staff, and sought help from world-renowned experts in the field. Among many other essential topics, these courses covered immediate management of traumatic injuries, long-term management of spinal injuries, management of chemical attacks, emergency obstetric management, and Surgical Treatment in the Hostile Environment, which is a highly-acclaimed course run in co operation with the David Nott Foundation.

The Syrian conflict created a significant and comprehensive challenge in terms of the delivery of health care to mass casualties, civilian populations and displaced communities. Maintaining and advancing delivery of health care in these circumstances is fundamentally important, and it requires uncompromising commitment to the humanitarian spirit and a desire to do one's best to help fellow human beings. It also provides an unparalleled opportunity for health care professionals to be part of something amazing!

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Caring for Muslim Patients

(By Prof Aziz Sheikh & Dr. Abdul Rashid Gatrad, 2000)

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As healthcare professionals, we are exposed to the beauty of the British population with its varied religions, numerous ethnicities and cultures. However, this key characteristic of the demographic of the UK can be an added challenge when dealing with a specific sub-population whom we are unfamiliar of their rules and customs. In this short and concise piece, the editors have collated pieces from a variety of authors to educate the reader, mostly healthcare professionals, on the background of the Islamic faith, in addition to important issues to be understood when caring for a patient who identifies as a Muslim.

The book is split into three main sections. Firstly, an overview of the Muslim faith and secondly, a more specific focus on important issues when caring for a Muslim patient. Finally, the editors give important resources including contact information for important organisations, as well as the meaning of some important terms relating to health in the Islamic faith.

Having been written in the early 2000s, many of the statistics in this edition are outdated, and the concepts regarding the assumptions of Muslim patients have progressed, however this book presents a reminder for the progress still to be made in educating the Muslim population in the UK on specific issues. However, for a high-level overview, this book is an essential read for any healthcare professionals caring for a number of Muslim patients, to better understand their patients and the external issues they have to deal with outside of the immediate symptoms or issues the patient is presenting with.

Section one starts by giving an overview to the demographics of UK Muslims, as well as their socio-economic position, before presenting an overview of the Islamic beliefs and the intersection of health and religion from a Muslim perspective. The authors of these chapters, all academics, give a balanced and objective presentation of Islam, ensuring to explain Islamic concepts that might present barriers to complete communication between a healthcare professional and a patient.

Section two is the gem of this work, breaking down important contextual issues as well explaining important events and chapters in a Muslims life. The editors chose, rightly so, to begin this section with a chapter discussing the family of the patient. While some of the mentioned points seem trivial and not directly linked to the care of a Muslim patient, they are important points to understand for the healthcare professional to better deal with what the patient themselves might have gone through or are going through, when completing a consultation. The book does have a south Asian bias, referring to the moving of a bride to the home of her husband's family as usual, which is not the case in the Arab culture for example. This could potentially lead to incorrect assumptions when dealing with a Muslim patient, which may be a point to consider in an updated version of this book.

The section then progresses to discuss issues related to the birth customs of a Muslim baby. Again, this section mentions some cultural issues faced by healthcare professionals concerning the naming systems of some sub-groups of the Muslim population, providing a helpful insight for non-Muslim readers. The book then addresses two important events in a Muslims life, the yearly worship of fasting in Ramadan, and the once-in-a-lifetime activity of going to Hajj. Out of all the chapters in this book, these two are the most important for all healthcare professionals, to be able to care for the patients in a complete manner. The authors of these chapters give a comprehensive overview of the worships before the potential health implications such as missed doses and hospitalisation for fasting, and the issues of infectious diseases and dealing with extreme heat and sun when completing Hajj. These are essential as Muslim patients should feel confident that their healthcare professional understands the issues they deal with in their life, while a healthcare professional should be able to understand the importance of these worships, and subsequently tailor the treatment or solution to the patient's needs.

The authors then conclude this section by discussing death, a key issue in the Islamic faith, even if the patient has passed, to respect their wishes. The authors highlight the divided opinions on matters such as organ donation, as

well as the feelings towards death, and a difficult decision some families have to make when their loved ones suffer in their final days. The final chapter in this section discussing how healthcare professionals can bridge the gap when dealing with their Muslim patients, and the education gap that is sometimes present.

Resources, such as the one reviewed here, are essential as the demographic of the UK continues to evolve, and healthcare professionals are dealing with individuals from even more religious, cultural and ethnic backgrounds. More should be done to make these resources up to date and more accessible for the wider healthcare population, in addition to similar editions for other sub-sets of the demographic. Future editions of books on this topic should take care to differentiate between culture and religion, clearly marking the religious requirements compared with the cultural, as this book has attempted to do.