Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Multifaith chaplaincy

Sir—In pluralist societies, the spiritual needs of all faiths should be identified and provided for,[1] yet the needs of an estimated 3 million Britons who subscribe to non-Christian faiths remain largely unmet.

The notion of multiethnic chaplaincy was first introduced through the link workers of the 1980s Mother and Baby Campaign.[2] Trained to deliver cultural awareness, they increasingly found themselves being asked to help provide for the religious needs of patients of ethnic minorities and their families. Recognition of such a need for the service subsequently translated in some areas to the recruitment of religious leaders prepared to give their time on a voluntary basis—a system still prevalent in many areas. Such services are, however, patchy, often being delivered by individuals who lack appropriate training, support, and quality-control checks on the nature of the care being delivered. However, progress is being made with two approaches: development of generic multifaith chaplaincy services and of more faith-specific models.

The first approach is based on all chaplains undergoing a broader training programme than hitherto provided to ensure they are able to fulfil a generic role if called upon. Being multilingual poses a distinct advantage in our experience. The big disadvantage with generic chaplains is that they cannot join in worship with patients of a faith different to their own, nor can they use the spiritual methods, which a particular faith would use to meet the specific needs of the patient—such as Muslim supplication or absolution for a Christian—to restore a sense of balance, wellbeing, and to give strength.

The second approach involves the deployment of faith-specific chaplains. Although this option makes sense on several fronts—eg, it can potentially overcome theological, cultural, and language barriers—an obvious disadvantage is the sheer number of religious and denominational chaplains that would need to be employed.

Pragmatic considerations suggest that a combination of approaches is probably the best way forward. Results of a British census[3] indicate a clustering of faith communities in certain urban areas—for example, large numbers of Hindus in Harrow (London) and Leicester, Sikhs in Southall (London), and Muslims in Bradford and several London boroughs. In such areas, faith-specific chaplains would be appropriate. In areas of religiously diverse populations, but with smaller non-Christian populations, generic chaplains might be more suitable.

Whatever approach is adopted, certain minimum criteria should be met, including basic training, a commitment to continuing professional development, and an advocacy role to meet practical needs, such as provision of adequate worship. Additionally, faith representatives should have the skill to deliver spiritual care, and the service should be comprehensive, transparent, and accountable.[4]

Understanding of cultures will, we believe, help to decrease prejudice, ignorance, and fear. Whether we believe in God or not, most of us have a sense of the spiritual through which we recognise a deeper meaning to life. Although religions are diverse, they share a claim to divine inspiration and the imparting of moral truths and guidance passed down through generations. Such beliefs, prayers, symbols, and ceremony, help individuals in times of celebration and tragedy to give meaning to moments of intense human experience.

Aziz Sheikh chairs the Research and Documentation Committee of The Muslim Council of Britain.

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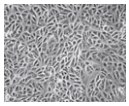
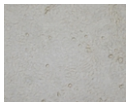
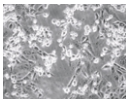
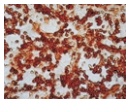
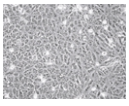
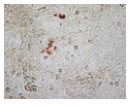
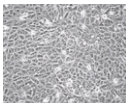
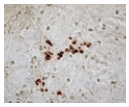
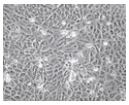
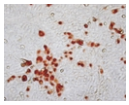
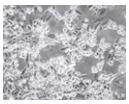
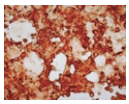
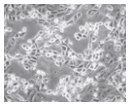
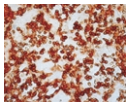
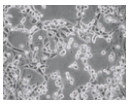
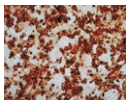
1 Department of Health. The patient's charter. London: Department of Health, 1999.
2 Rocheron Y, Dickinson R. The Asian mother and baby campaign: a way forward in health promotion for Asian women? *Health Ed J* 1990; **49:** 128–33.
3 National Statistics. Census 2001. http://www.statistics.gov.uk/census2001/default.asp (accessed May 24, 2003).
4 Orchard H. Hospital chaplaincy: modern, dependable. Sheffield: Sheffield Academic Press, 2000: 127–35.

DEPARTMENT OF ERROR

Cinatl J, Morgenstern B, Bauer G, Chandra P, Rabenau H, Doerr HW. Treatment of SARS with human interferons. Lancet *2003*; ***362:*** *293–94*—In this Research letter (July 26), the figure should have appeared as below.

SARS–CoV (MOI 0·01)	Interferon β (IU/mL)	Native	Immuno-staining	Mean log virus titre (SD) Infectious ($TCID_{50}$/mL)	Genomic (RNA copies/mL)
–	–			0	0
+	–			6·99 (0·08)*	10·23 (0·19)*
+	10 000			2·28 (0·27)	6·81 (0·27)
+	2000			2·84 (0·43)	7·15 (0·17)
+	400			3·62 (0·35)	7·79 (0·53)
+	80			6·41 (0·34)	9·63 (0·48)
+	16			6·74 (0·09)	9·96 (0·37)
+	3·2			6·93 (0·21)	10·18 (0·41)
				EC_{50}=31	EC_{50}=17
				EC_{90}=85	EC_{90}=72

Effect of interferon β on replication of SARS-CoV strain: FFM-1 in Vero cells 72 h after infection
Virus detected in serum with peroxidase staining. *Values represent mean (SD) from three experiments, each done in triplicate.