

# Muslim Spiritual Realities and Their Impact on Health and Healing

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## **Executive Summary**

This research project explores Muslim sensitivities towards healthcare issues through the identification of key issues Muslims face when accessing healthcare in Edmonton, as well as how they approach issues relating to Islamic spirituality and newer medical technologies. The project consisted of both a qualitative component consisting of focus groups and interviews with 30 Edmonton area Muslims, as well as a textual review of Islamic positions on certain healthcare practices. The focus groups allowed us to identify what some of the issues are that face Muslim patients when accessing healthcare, and how some members of the Muslim community approached newer medical technologies. This exploratory component was recorded, transcribed and the results were summarized into simple points. The report is segmented into four main sections. The first two sections summarize results from focus groups pertaining to questions regarding patient interaction with healthcare systems in Canada together with responses to mock scenarios presented to participants pertaining to new medical technologies. The third and fourth sections of the report offer a brief summary of some of the Islamic positions relating to the same medical issues, followed by some concluding remarks. This summary of positions offered (and discussed within the report) by various Islamic jurists and scholars is key in illustrating the breadth of opinion that exists on a single medical issue and how these positions may or may not be reflected in the opinions of our Muslim focus group participants.

Results: Our results indicate that, for the most part, Muslim patients in Edmonton do not feel that healthcare professionals treat them any differently owing to their religious/cultural background. Participants were split when it came to preference for a particular gender of doctor, and generally, participants who did prefer a particular gendered doctor felt that their needs had been met. On the question of whether or not participants had questions regarding new medical technologies and if they would seek help (and through what means) with finding responses, many suggested that they did indeed seek help, but how and with whom these questions

would be discussed varied greatly. For many, particularly younger participants, the Internet was a point of entry into seeking answers to particular medical questions. Some responded that they would seek counsel from their local Imam, while at least one participant noted that she was not comfortable speaking with an Imam about private medical issues. Almost all participants felt that there was a need to have more information made available to them about the Islamic position on some of these newer medical technologies. Results from our case studies indicated that there was a breadth of opinion amongst the Muslims whom we spoke with respect to abortion, stem-cell research, and end of life care. This diversity of responses, in turn, corresponds with the diversity of opinions offered by (and discussed within the report) various Islamic jurists and scholars.

**Conclusions:** Our research confirms the existence of multiple opinions among both Islamic scholars and jurists and Muslim patients when it comes to certain elements of healthcare and religious belief. This diversity within the Islamic tradition is similar to those existent within other religious traditions, but with different nuances that are particular to the tradition. Many of these nuances have to do with the type of Islam that is under consideration (Shia, Sunni, Shia Ismaili, etc.) and the ways in which scholars and jurists approach Islamic bioethics (for instance, through a reliance upon Quranic texts, through the Islamic traditions of qiyas, ijma, or istihsaan, etc.). What develops out of these traditions is a rich, and varied body of laws and edicts that usher patients towards a more Islamic approach to receiving healthcare. Ultimately, it is critical for healthcare practitioners to familiarize themselves with the doctrinal language that these bioethical issues are coated in so that they can best meet the needs of their patients in a culturally competent manner.

**Keywords:** Islam, Canada, Healthcare, Bio-Ethics, Cultural Competence

"We must accept Allah's will. We must not play God."

(Focus Group Respondents)

"We have to protect lives at all costs...it is demanded of us in our faith."

(Focus Group Respondents)

### **Research Background**

Islam is the youngest of the world's major religious traditions belonging to the Abrahamic family of faiths. Beginning nearly 1400 years ago, it is a religion that, today, over a billion adhere to--covering almost every continent around the world. The faith continues to grow at an unprecedented rate with the Muslim population expected to increase by 35 percent in the next 20 years to roughly 2.2 billion by 2030—a forecasted growth of twice the rate of the non-Muslim population over the next two decades (Pew Forum for Religion and Public Life, 2011). In Canada, this trend continues as well, with the number of Muslims expected to triple in the next two decades from roughly 940,000 in 2010 to approximately 2.7 million in 2030 (Pew Forum for Religion and Public Life, 2011). These statistics become all the more relevant when considering new research which suggests that people from minority groups experience a far lower quality of healthcare and are faced with additional and more burdensome barriers in accessing and receiving healthcare services compared to non-minority populations (Smedley, B.D., Stith, A.Y., Nelson A.R., 2003). Additional evidence reveals a strong and critical link between a lack of cultural competence in healthcare providers and poor quality health outcomes (Johnstone, M., Kanitsaki O., 2005).

In the foreground of this rapidly shifting Canadian demographic landscape, these aforementioned findings demand a more thorough investigation into the role of spirituality and culture and existing healthcare practices and policies. While the provision of compassionate care has always been at the heart of the healthcare profession, the sharp increase in the number of Muslims in Canada has made this

endeavor towards implementing more culturally sensitive healthcare both necessary and compelling.

To explore this vital topic, the body of research was assessed so as to be able to collect and disseminate information pertaining to Islamic positions regarding various medical procedures, acts of piety, and healthcare practices. It is our hope that, in the future, the information that we have collected here will be used to create a mobile application that doctors, healthcare practitioners, and Muslims can easily access when faced with particular medical circumstances. It is our belief that this project is reflective of our current times both demographically and technologically and that it will not only be of great use to members of the Muslim community, but also to doctors and other healthcare professionals by enriching their cultural competence in dealing with Muslim patients.

In order to address this broad issue, we developed a research project that involved a four-fold approach aimed at four distinct areas of inquiry. First, was an analysis, and identification of key health concerns and predicaments that most affect Muslim-Canadians. These were typically issues where the community was either not in consensus about, due to an ambiguity within textual or legal Islamic sources, or where there was an issue regarding gender or cultural discrepancies. From our previous research, for instance, we knew that several of these pressing issues included the following; the doctrine of ensoulment of an unborn child and issues concerning the timing of abortion; authority notions related to determining when the human is technically “brain dead” and can thus be removed from life support; diversity of opinions concerning female modesty and cultural and religious barriers faced by Muslim women in attaining proper healthcare (Waugh E., 2013). These are questions that individuals within academic circles have lightly touched upon, but predominantly from a scholarly, legal perspective and not necessarily from the viewpoint of Canadian Muslims faced with multiple claims upon them.

Second, we were interested in further exploring the variance of opinions that exist on selected issues as reflected by the diversity of Muslim religious and cultural narratives, and furthermore, how these perspectives affect adherents' pursuance of healthcare. Third, we were interested in better understanding the ethical implications of a number of newer technical medical procedures and what implications they may have for Muslim patients. Examples of these new technologies include, for instance, stem-cell research, new fertility procedures, and islet transplants. Because these procedures are so modern, traditional guiding principles of Islamic rules and conventional expressions of piety offer no clear-cut answers as to the appropriateness of their use within a religious context.

Finally, taking into consideration these earlier areas of inquiry, this body of research aimed to better understand how these varied Islamic perceptions affect current patient-provider dynamics. By extension, the research also worked to better understand the various barriers that may exist in accessing and receiving healthcare amongst Muslim populations in Canada. We specifically chose to focus on these specific areas of inquiry as we felt that they were critical in the formation of a better understanding of current Muslim spiritual realities, their impact and health and healing, and the ways in which Muslims articulate spiritual processes when facing medical/health issues.

Until now, this has remained an area of research that has received relatively little attention among professionals and the scholarship that has been conducted in the area has largely been limited to academic circles and not been readily available to those who could most benefit from it—primarily Muslims and healthcare practitioners. As such, we feel that the potential influence and impact of this project will reach well beyond the social science and healthcare research community. We have approached these various areas of inquiry doing our best to acknowledge the possible presence of other, non-religious variables such as gender relations and structural family dynamics, and their potential relationship with particular religious and cultural perceptions.

### **Research Methods**

Unlike other nations, in Canada almost all the basic growth of the Muslim tradition has come from immigration. There is no equivalent to the Black Muslim movement in the US that has impacted directly on American culture and politics. Immigrant Muslims have intense pride in their countries of origin because they appreciate the cultural achievements of their homeland. Thus part of Canadian Muslim identity is linked irrevocably to other places, even if they were born here.

This is experienced in various ways. For many, their 'homeland' cultures are far older than those they encounter here; some immigrants experience a disconnect between the relative cultural wealth of their homeland in contrast to its financial poverty when compared to the West-- for many the West is culturally inferior. Muslim immigrants in the last census were from a range of countries that can be identified by regions: Africa (Sudan, Somalia, Morocco, Egypt, etc), Middle East (Iran, Syria, Lebanon, Turkey, Palestine, etc), East Asia (Pakistan, Bangladesh, India, Indonesia, etc), Asia (China, Russia, Afghanistan, etc). These distinctions do not exhaust the variety.

Even when the major ethnic divisions are noted, the Islam to which many Muslims belong may not coincide with that from another region of the world. There are major cultural differences in the 'Islamic' nature of these countries because the tradition has taken on both national and ethnic coloration as it developed. For example, North American Muslims express themselves in the ancient religious divisions of Sunnism and Shi`ism; mosques and religious organizations retain this primary division fairly rigorously. At the same time, there are significant numbers of believers who do not find this a critical part of identity.

Thus, in introducing the specifics of our project it is important to stress that one of the functions of this research is the recognition that the term “Islamic” or “Muslim” is a broad designation, at best and that it does not accurately depict a singular belief system or perspective. Indeed, Muslims globally cut across a variety of subgroups and demographic designations. Despite the fact that Muslims tend to share a common worldview, these social, cultural, and economic differences do have an effect on the way that Islamic health care is perceived and approached by the adherent. To this end, this research does not argue that the influence of religion is more critical than other influences such as ethnicity, and socioeconomic status, or that religion can even be separated from these other influences. Rather, it suggests that Islamic perceptions of adherents give rise to particular understandings of health and healthcare and that these perceptions can vary immensely.

Our central mandate, then, is not to draw normative conclusions regarding the correct Islamic positions on healthcare practices, but rather to make sense of the relationship between perceptions of Islam and healthcare attitudes. Furthermore, we also recognize that Muslim beliefs are often couched in cultural beliefs. Underlining this important fact is a critical first step in initiating this particular type of research. Also important to note, as part of our methodology, is that this research presents a *Canadian* perspective on Muslim healthcare issues. While our textual research is global in nature, it remains that our participants reflect Canadian-Muslim sentiments, and their experiences and beliefs are molded, in large part, by a very Canadian ethos.

The methodology employed during the course of this research was purposely chosen to reflect the complex nature of our study. We thus opted for a methodology that allowed us to blend our textual research with structured focus-groups. Our first point of entry into this research project was our own research in the area of Islam and healthcare practices. Until now, our research had focused on the intersection of faith and health, especially as it pertained to cultural influences on plan of care, end of life concerns, and contemporary religion and health issues. In

building upon these areas we have expanded our use of textual sources to reflect a wider diversity of literature. We have employed several key databases such as *JSTOR* and *PubMed* in gaining access to key articles and journals that speak to our subject area from a scholarly position. Furthermore, we have employed a variety of Islamic textual sources that speak to similar issues from the Muslim perspective of ethics and spirituality. Finally, we have relied on various journals and databases that have provided key information on the delivery of healthcare practices such as *Health Policies* and *Medical Bioethics*.

While the textual components of this research project have helped to create a robust framework of issues, the real core of our research has come from the information that we have gathered from our personal communication with members of the Edmonton Muslim community. That being said, however, it is worth mentioning that in the initial design of this research project, it was our intent to interview 10-12 Muslim doctors in the city to obtain their perspective on the delivery of healthcare to Muslim patients. We felt that this was an important area for our research as they could provide us with invaluable information about both the types of questions that patients ask them (owing to their dual position as both Muslim and physician), and the types of responses that the physicians would give to their Muslim patients on certain healthcare questions. (For a list of the proposed question please refer to appendix 2. We have included the questions in this report as we feel that they are important to ask, and perhaps a future research study could benefit from them.) Much to our frustration, however, every single doctor (with the exception of one) that we approached with this project did not, for one reason or another, wish to participate. While most all of them supported the research and felt that it was an important and worthy endeavor, they, for reasons that we can only surmise about, chose not to go on record.

It is our opinion that many of these doctors may have chosen not to participate as they may have felt a level of intimidation in speaking on issues that were so morally

and ethically grounded. In so doing, some may have felt that they would be somehow undermining the authority of religious leaders or scholars. Because in some circles the Islamic community in Edmonton can be quite tight, some professionals may also not have felt like it was their place to be the voice of the Muslim medical community. Ultimately, these are our own assumptions as we try to understand why it is that we could not fulfill this one, very essential, component of our research project.

In the end, in order to somehow compensate for this deficiency, we chose to include the section on Islamic perspectives on healthcare issues. We feel that this section adds a valuable component to the research as it provides for the reader, what the authoritative positions on various medical issues are according to Muslim jurists and scholars. In many ways, this section not only fills the void created by our inability to interview local doctors, but it also provides interesting insights into some of the issues that earlier were raised in our focus group interviews.

### **Recruitment Methods & Interviews**

Our primary aim for this research was to have participants from a broad cross-section of the Edmonton Muslim community. We successfully ran five separate focus groups with a total of 30 participants, with representation from the following Muslim groups: The *Canadian Council of Muslim Women* (CCMW), the *Al-Rashid Mosque/Canadian Islamic Center* (CIC), the *Islamic Shia Ithna-Asheri Association of Edmonton*, and the *Edmonton Ismaili Jamatkhana*. We specifically chose representatives from these particular groups so that we could ensure that opinions expressed would be representative of a wide Islamic perspective including both Sunni and Shia. Additionally, we are careful to ensure that we had a good turnout of female participants (we had a total of 17 women and 13 men), so as to better understand those issues pertaining to women's health needs and access to healthcare.

Initial contact was made to the groups through email and phone calls. Potential participants were made aware of the research through recruitment by individuals within particular groups, and through website, and oral announcements. We provided each contact within the various communities with information packages, which included a detailed information sheet with respect to the research, together with contact advertisement pages.

Focus groups were mostly held within meeting spaces of the respective communities, with the exception of one focus group that was held in a corporate board-room. Most group sessions ran approximately 90 minutes long with roughly half the time spent on short questionnaire questions, and half on case-study scenarios. During the focus group interviews, both written notes were taken, as well as tape recordings. This information was, in-turn, analyzed and summarized into our findings.

### **Break Down of Report**

The report is broken up into four main sections. The first section offers a synopsis of responses and comments from our focus group questions regarding patient interactions with healthcare systems in Canada. In the second section, we offer a synopsis of responses from the more detailed scenario questions given to our participants. These scenarios touched upon areas such as abortion, stem cell research, and end of life care. In the third section, we offer a brief summary of the Islamic positions on these same areas. In this way, we are able to compare what Islamic scholars and jurists state upon a particular case, and where the members of the Muslim population that we interviewed stand on the issues. Following some concluding remarks regarding our findings, we also have added a small appendix at the end some issues that may be of interest for healthcare workers when working with patients in a hospital setting, and our proposed list of questions for Muslim healthcare practitioners.

### **RESEARCH FINDINGS:**

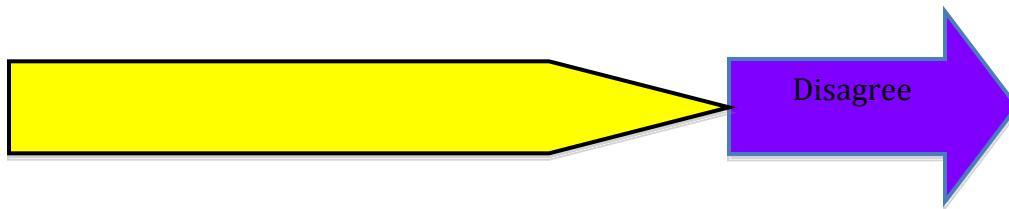
In the following section we have provided a copy of the questions that we asked focus group participants, together with a general summary of responses. After a general summary, we also have included specific stories, as well as minority opinions expressed during the sessions.

### **Analysis of Responses**

#### *Focus Group Questions*

- 1) Have you ever felt that doctors and other healthcare practitioners treated you differently because of your background (cultural or religious)?

Most were in agreement that they were NOT treated differently because of their background; purple arrow represents dominant percentage of remarks.



Overall there was a general sense that Muslims interviewed did not feel in any way discriminated against by doctors or other medical professionals. This correlated with what majority of participants felt was a changing demography with doctors (they are more culturally diverse). Additionally, majority participants felt that there was a difference in attitude based on age, whereby older generation Muslims have issues with communication and language and prefer same gender doctors, while younger generation Muslims don't have the same language barriers and are more comfortable with different-gender doctors.

- a. One example that was cited was a struggle between doctor and family of a patient on life support, where the doctor strongly recommended terminating life support, while the family insisted on keeping it on

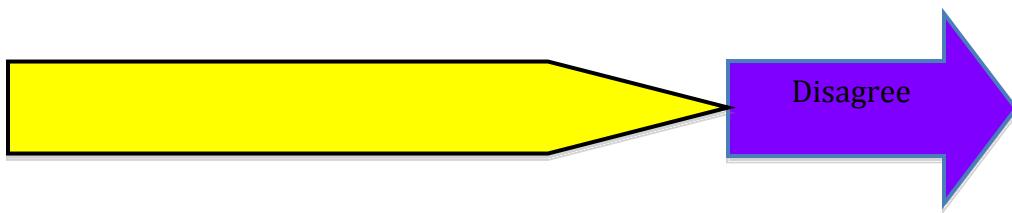
religious grounds. While the family wanted to keep the patient on life support on religious grounds, the doctor was recommending taking patient off life support on compassionate grounds (was not made aware of families religious beliefs, and therefore could not be accused of ignoring them). In another example with the exact same scenario, family felt that doctors and healthcare practitioners were very supportive of their decision to keep patient on life support, despite their suggestion that he be taken off. Family felt as though their beliefs were being respected and honored by healthcare practitioners. Finally, an important point that was raised by one participant was that there may exist a vulnerability regarding what a patient's rights are in a hospital if they are new to the country and do not necessarily understand the hospital system. An example of this is the right to refuse student practitioners into the exam room.

- b. At least several participants mentioned that some hospital rules are not amenable to "Islamic" culture. Among factors that were mentioned were the abundance of visitors that visit a sick person in the hospital (staff get overwhelmed) and visiting hours (families from certain cultures tend to want to stay with patient beyond standard visit times). Overall, however, it was noted that once these demands have been made, hospitals have been generally good at accommodating patients and families. In one group it was noted that hospitals have been especially understanding about large gatherings of family and friends at hospitals particularly following a death.
- c. Several participants expressed having had negative experiences regarding dietary restrictions within a hospital setting whereby healthcare practitioners showed little regard for dietary needs despite

constant explanation to staff regarding expectations. In one case nurses were unaware of what "halal" food was.

- d. One participant felt that doctors in a hospital asked inappropriate questions regarding how many children they had. Did not seem to understand that larger families are commonplace in certain cultures.
- 2) Have you ever felt as though a doctor or other healthcare practitioner has not been sensitive to your religious background when giving you health advice? How about in a hospital setting?

Most were in agreement that most physicians and other healthcare personnel had been sensitive to their cultural and religious backgrounds both in and out of hospitals.



Examples include the offering of halal foods, allowing families to bring in food from outside, asking before animals (therapeutic dogs) are brought into rooms, and so forth. Cleanliness is hardly an issue as most participants felt as though rooms and bed sheets were well maintained by staff. Across focus groups there appeared a consensus that doctors and other healthcare practitioners were sensitive to religious background when necessary, but that it was very rare that special religious sensitivities needed to be addressed. Some participants who required doctors to make alternate suggestions regarding diet and/or medication due to religious

reasons, felt that their needs were addressed with alternative treatments, and if the doctor had any questions regarding religious-cultural preferences that they would ask in a respectful manner.

- a) Under this point, at least 2 groups in particular felt that there was a certain level of pressure exerted by doctors and patients and families regarding abortion. We heard at least 3 cases wherein doctors pressured families into abortion without considering what participants believed to be the Islamic perspective against abortion. It was mentioned, in relation to this point, that doctors often give very swift responses regarding abortion without providing proper reasoning for their suggestion, or without entertaining alternative scenarios.
  - b) One participant felt frustrated by the fact that her doctor kept recommending swimming to her as a form of exercise, despite the fact that, because of her belief system, swimming was not an option for her. At the same time, however, the participant expressed that she didn't mind that the doctor kept making this recommendation of her because it showed that the doctor did not make any assumptions about her based on her outward appearance. This type of comment is interesting as it reveals a fine line between practitioners displaying a certain level of cultural sensitivity, while at the same time not making assumptions based on appearance / names.
- 3) Do you, for religious purposes, prefer to see a particular gender of doctor over another? Have you always been accommodated?

Overall, respondents appeared split on this question



## Some Perspectives from Respondents

- a) Throughout most groups there was a general agreement that gender of doctor came second to skill and ability, with most participants opting to see (in particular specialists and ER doctors) that were most capable, and not necessarily of a certain gender. For women's physical exams, however, there was agreement across groups that most participants would prefer to see a same-gendered doctor, but more due to comfort levels than religious proclivities.
- b) Also, under this point it was mentioned by more than one of the groups the need for more female doctors (especially obstetrician/gynecologists), as it was felt that wait lists for these doctors were generally very long, and there were not very many to choose from.
- c) Regarding this question some felt that there was still room for improvement in terms of doctors / nurses walking into the rooms of female Muslim patients and not permitting sufficient time for the female patient to cover herself should she choose to. Related to this point, however, is the general feeling that increasingly, doctors and healthcare practitioners are more knowledgeable about proper etiquette when it comes to particular cultures.
- d) Generational differences. Almost a third of participants expressed that younger Muslims do not have as many issues with seeing opposite gender

"The doctor is always advising me to go swimming for my knee, and its frustrating because he doesn't realize that I can't go swimming in a public pool because of hijab...but at the same time it shows that doctors don't make assumptions because of my culture"

(Focus Group Respondent)

doctors as older generations do. Many felt that this had more to do with culture / upbringing than religious preference.

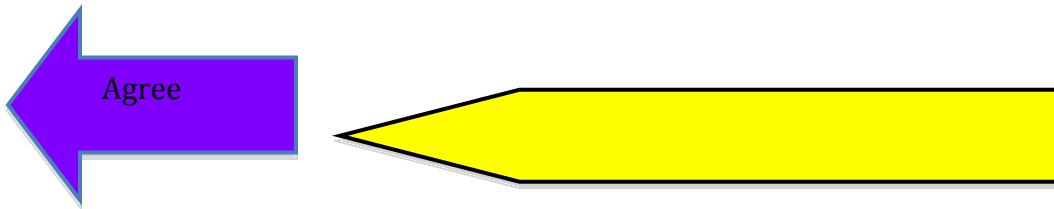
"For issues that I am not sure about I look it up online. I recently looked up birth control to see if it was permitted or not...its more comfortable than going to the Imam"  
(Focus Group Respondent).

- 4) Have you ever asked someone for religious guidance for a particular medical issue? Were you satisfied with the response?

AND (these two questions were asked together)

- 5) Where do you often go for guidance for these particular medical issues? Is it easily accessible? If not, what would you like to see put in place to better address your needs

Because of the open-ended nature of this question it is difficult to chart the results, however, in terms of going to an individual for guidance on a particular medical issue, the majority of respondents responded positively.<sup>1</sup>



### Some Perspectives from Respondents:

- a) Several respondents mentioned that when they had questions pertaining to healthcare that their first instinct was to use the Internet both to search items such as "birth control AND Islam" as well as to look up online fatwas, or possibly emailing religious authorities.
- b) Some would approach their local Imam for answers regarding medical questions (i.e. the permissibility of taking pills coated in gelatin, and abortion were among the most asked questions). It was also mentioned, with respect to this point, that at times Imams work/consult with a group of doctors on certain issues pertaining to Islamic law and healthcare questions.
- c) Asking other Muslim doctors within ones congregation
- d) The mention of making personal decisions based on ones intellect, rational thought and personal understanding of faith. Do not necessarily follow a particular doctrinal prescriptive.
- e) Generational differences – younger generation tend to go to the internet while older generation tend to go to mosque/imam for answers
- f) At least two participants mentioned some hesitation with going to the Imam (felt uncomfortable asking personal medical questions from him).
- g) Numerous participants expressed a desire to have a central website for healthcare workers and patients to go to as a general resource guide for Islamic positions on healthcare. On the other hand, however, there were a few participants who believed that there is no need for a central resource of

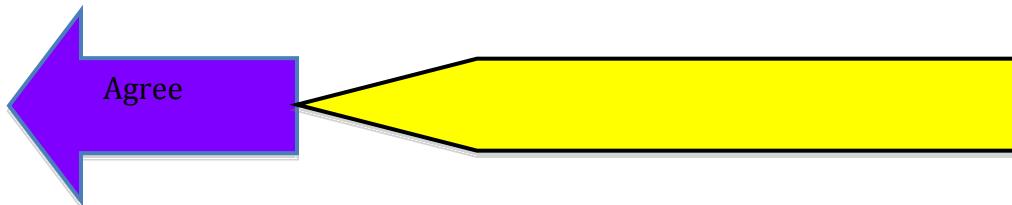
information for medical issues in Islam, as these decisions are personal and based on personal preference.

Also in relation to this question was the comment from one focus group participant that there is a general belief among Muslims that “if you need to question it (regarding the Islamic permissibility of something) that you are better off without it.”

“There is a certain vulnerability regarding what rights are in a hospital...there are certain rules in a hospital that culture does not handle too well. Things like too many visitors, respecting visiting hours, turning away student practitioners...doctors walking into rooms when women are not properly covered...we have to make our demands known and most often the doctors will accommodate” (Focus Group Respondent).

- 6) Have questions ever arisen for you with regards to newer medical technology (such as islet transplants, or organ transplants) and their compatibility with your faith?

Overall, most respondents did, at some point, have questions with regards to new medical technologies and their compatibility with their faith.



## Some Perspectives from Respondents:

- a) Anything that enhances life is permissible. In a similar vein another group stated “whatever is for the common good is good to do.”
- b) Important to check with experts on permissibility
- c) Overall humanity should guide decisions regarding new medical technologies
- d) Decisions should be made on a case-by-case basis in consultation with doctor and family.
- e) Cultural practices from back home versus Canadian cultural norms when it comes to end of life care. In this particular case, the patient wanted to die at home as was customary in his culture, however, the family did not want to be accused of not taking him to the hospital when it became apparent that he was not going to make it.
- f) Importance of interpretation and change in medical Islamic health ethics. So for instance, one participant felt that because there is evidence of god's guidance shifting in the Koran, so too it is understandable that one may change their position on certain Islamic healthcare positions depending on circumstances.

## *Case Studies*

### **Case 1 - Abortion**

“How aggressively are we supposed to treat sickness? Are we sentencing this person to a life of hell because of our religious beliefs?”

(Focus Group Respondent).

Sakina and Ali, a devout Muslim couple, are excited to hear that they are pregnant with their first child.

They find out during a routine ultrasound that the baby is a girl and they decide to name it Aliyah. Unfortunately, their excitement does not last long as a subsequent ultrasound reveals what doctors believe to be a birth defect. Additional testing reveals that the 20-week old baby has a hole in its diaphragm, a condition known as congenital diaphragmatic hernia or CDH. In the case of baby Aliyah, her stomach and liver has moved from the abdomen up into the chest cavity and is preventing the development of the left lung. The doctors tell Sakina and Ali that one in every 2,500 babies suffers from CDH, and about half of these babies die. They also advise the parents that for Aliya, the prognosis does not look good. For Sakina and Ali, abortion is out of the question as they feel that, according to their belief system, the fetus already has a soul, and to now terminate the pregnancy is akin to murder. They strongly feel that they ought to be content with whatever God gives them, as he alone is the sole legislator over life and death. The doctors, however, advise them that to repair the hernia would put baby at risk—there is no evidence that the baby would survive, and there is no evidence that they mother will not be harmed. Furthermore, in the off chance that the baby did survive, it would likely require numerous surgeries, around the clock care to manage her breathing, and a long list of medications. The couple prays and they turn to their local Imam for guidance.

#### Notes:

The issue guiding this question is the permissibility of abortion when the fetus is past the generally agreed upon 3-4 month period of ensoulment. The mother's life is not specifically in danger, although it cannot be entirely ruled out. Furthermore, the livelihood of the baby, if carried to term, and its quality of life is questioned. The child, if carried to term, will likely need great medical intervention, which would be a great use of time and resources.

Given these factors, we anticipate that subject participants will focus largely on the ethical dilemma surrounding the abortion of a fetus, after the period of ensoulment, and according to their understanding of the laws of Islam regarding abortion.

## **Summary of Responses:**

Generally speaking, participants responding to this question ranged from the permissibility of abortion according to Islamic law, the impermissibility of abortion according to Islam, all the way to the importance in individual, rational decision making, independent of strict doctrinal law.

Either they felt that the baby could be terminated on the basis of using reason and common sense, and within the larger subset of ethical instructions, or they felt that, according to their understanding of Islamic law, the child could not be terminated as it had already been ensouled. A majority of all participants noted, however, the emotional difficulty associated with making such decisions.

Some participants felt that the baby could be terminated on the basis of using reason and common sense, and within a larger subset of ethical instructions. In such a scenario, one could argue for abortion as it would not be ethical to bring to the world a child that would be riddled with issues and the prospect of a difficult life. Moreover, within a larger ethical framework, the money associated with caring for such a child, when there is the option to abort, and to otherwise spend such funds on existing medical needs may supersede the necessity to carry such a pregnancy to term.

In one example a couple decided to refuse the abortion of a congenitally ill baby, and the baby died soon after birth, but the couple had no regrets because according to Islamic law you must accept what Allah gives you, and as such you must accept a baby in any form or condition. Several other participants also pointed out that they knew families who kept babies that doctors had recommended to be aborted. While the children did not live long, they nevertheless had no regrets regarding their decision to keep the child. This follows in line with their belief that Muslims do not have the authority to abort a fetus outside allowed perimeters (which did not exist in the case study).

For some participants, the question was clearly one of faith. Under no circumstances would they recommend abortion due to the belief that ensoulment occurs at 4 months, and because of the belief that the only reason that an abortion is ever permissible within Islam is if the mother's life is at risk. Yet, at the same time, some participants did acknowledge that even among Islamic schools of jurisprudence there is some disagreement about this time frame regarding ensoulment.

One participant noted that because Muslims take such a strict position on abortion it is critical that the diagnosis be accurate, and perhaps even supported by another doctor. For another participant, they felt that on the one hand there is the belief that we cannot, as humans, even ascertain the future of so-called healthy babies. Not knowing what the future holds it is necessary that the precepts of Islam are followed, that the baby be kept at all costs, and provided for with the best possible care, and to let nature take its course. Ultimately, the lesson is that it is not for us to decide.

On the other hand, some participants felt strongly about sentencing a child to a life of hardship all the in the name of religious belief, and if this act of piety is indeed what Islam stands for. In this instance, some felt that abortion might be a wise choice.

On the other end of the spectrum were those participants who felt that, according to their belief, there is no singular position on the matter of abortion. Rather, when faced with this type of situation they tend to speak to other members of the community, particularly those tasked with the responsibility of providing healthcare advice. This advice, however, comes more from a medical perspective (so that the patient gains a better understanding of what the issues are) rather than a religious perspective. Some may choose to accept the challenge of carrying the baby to term with the belief that this is what Allah wants, while others may choose to abort.

Either way, these participants felt that the community would support the very personal, and individual decision.

Additionally, some participants felt that individual decision trumps the Islamic perspective on abortion because the decision is really a private one between patient and creator. As such, respondents felt that their community generally tries not to advise on these sorts of decisions.

### **Case 2 – Stem Cell Research**

After trying to conceive a baby for several years, Leyla and her husband Arman decide to try in-vitro fertilization. This procedure combines the husband's sperm and the wife's ova to grow in a laboratory, from which several fertilized ova are then implanted into Leyla's womb. In the case of Leyla and Arman, they successfully give birth to twins and decide not to have any more children. There are left over embryos from their procedure that the couple decides to donate to the university for stem-cell research (loosely, one type of stem cell research involves harvesting cells from embryos for the purpose of reproducing human cell lines and tissues). The particular lab that they want to donate the embryos to is dedicated to stem cell research in order to cure serious spinal cord injuries. Arman and Leyla feel that donating their unused embryos to stem cell research is an act of piety, as they believe in the principle that any attempt to find improvements that will aid in the quality of life is not only recommended but also required by Islam. Before donating the embryos, however, they discuss the issue with Leyla's uncle Hamid, who is not pleased to hear of the couples plan to donate embryos to stem cell research. Hamid feels that certain acts of genetic engineering, especially those involving the manipulation of cells involve "playing God." Moreover, Hamid is concerned with the fact that stem cell research requires the

"God gave us intellect to make decisions...Things are constantly changing, and interpretations are changing so it is hard to make a decision on issues like these when you really don't know what the future holds"

(Focus Group Respondent).

destruction of human embryos for the harvesting of stem cells. According to Hamid's understanding of Islam, an embryo, even in its first days of existence has the right to life, and that the harvesting of stem cells is not mentioned as a sufficient reason in Islamic legal circles for their termination. Having heavily considered Uncle Hamid's objections, Leyla and Arman are now uncertain what to do with their unused embryos.

#### Notes:

This issue of stem-cell research within Islamic circles is an interesting one owing to its relative newness on the technology front. What makes this particular case study interesting is that it raises critical questions regarding when an embryo can legally be destroyed according to Islamic law (ie, when it becomes ensouled), what role humans can take in manipulation of cells, and whether or not such an act constitutes "playing God," and finally, how this scenario lends to the popular Koranic edict that any attempt at finding cures to illnesses is an act of piety. Given that stem cell research is still a relatively new practice, we were interested to see how participants approach the subject of new medical technologies, whether or not such new technologies are a source of tension, and how they go about trying to resolve any questions that may arise from the use of new medical technologies.

#### Summary of Responses:

Responses to this question were again, rather varied. The majority of respondents felt that stem cell research should be permissible if they are used for the purpose of aiding others within a medical capacity. Many of these participants pointed out the importance of researching new cures within Islam, and the Islamic edict stating the importance of helping to save or better the lives of others as reasons for their support of stem-cell research. Additionally, some participants felt that there is no Islamic ethical issue associated with the use of stem cells harvested from embryos, specifically, as the embryos have not yet become ensouled and because the issue is

with regards to the use of primary cells (which also do not have a soul). One participant was adamant that while embryos can be used to harvest stem-cells, it nevertheless is against Islamic law to donate the embryos for the purpose of procreation because of Islamic laws dealing with issues of mixed lineage.

While the majority of participants approached this question with the belief that Islamic law either permits or does not permit a certain type of new technology (in this case stem-cell research), we did have several respondents who, similar to responses with the other case –studies felt that the issue was a deeply personal one. From their perspective, such decisions should be guided by how one interprets their personal faith, and that such issues should be viewed through an intellectual lens (where intellect is seen as a gift from God) as opposed to a broad “Islamic prescription.” As with the previous question, at least a handful of participants felt that their religious communities would not provide guidance to adherents on the issue of stem-cell research as these types of issues are not broadly discussed by religious authorities within their particular groups. Rather, the tendency is to wait and see how issues evolve, and then if need be, leaders within these particular communities will provide guidance on the matter.

Also expressed by a majority of participants was the inherent tension that exists between what God wants (fate) and “playing God” when it comes to new medical technologies such as stem-cell research. What we heard from participants on at least three occasions was that Muslims are, at once, taught to accept fate without question as the will of God while at the same time encouraged to research illness and seek new cures. This tension between accepting fate, and accepting new technologies—between the notion that God wants things a particular way and the Koranic belief that God has provided the cures for all diseases-at times causes for some confusion when faced with these types of issues. Loosely related to this is a point that was brought up by several participants regarding the correct usage of new medical technologies. While fully in favour of the use of stem-cells, some participants, nevertheless felt that safeguards need to be put in place to help against their mis-use (for instance using stem cells to build super humans). According to

one participant it is important that as a society we discuss the potential of these types of advancements, as this will be one of the biggest moral-ethical challenges that we face in our lifetime.

Several other points of interest that arose in relation this case study include:

- a. The need for doctors to be in tune to the diversity of Muslim opinions.  
Healthcare practitioners should encourage patients to make decisions that work for them, religiously and personally.
- b. Importance of not generalizing Islamic perspectives
- c. Doctors should have a basic understanding of Islam, but should not counsel patients towards or against a certain position that they believe the patient to have by virtue of their cultural / religious background.

### **Case 3 – End of Life Decisions**

Ahmad, 78, is in a coma. Fourteen weeks ago he stopped breathing and suffered heart failure. 10 minutes had passed before paramedics arrived at the home and transferred him to the hospital. Once there, physicians and nurses were able to get his heart beating at a normal rhythm, but had to put him on a respirator because he was unable to breathe on his own. A CAT-scan done later in the day showed very limited functions of his cerebrum and brain stem. Ahmad has shown no signs of responsiveness for nearly 4 months now. Ahmad has no living will and had not discussed the issue of life-sustaining respirators with his wife or 2 male children. Ruhan, Ahmad's eldest son believes that stopping his father's respirator or "pulling the plug" is akin to assisted suicide.

"I agree ethically [with taking patient off life support], but I am having a hard time deciding if I agree morally. Its tough."

(Focus Group Respondent).

Ruhan believes firmly in the Islamic prescription that life is sacred and a trust from Allah, and that death comes at the decreed hour for their ultimate spiritual benefit. In a meeting with his mother and younger brother Halim, Ruhan stresses that the Qur'an itself has declared that "...no human being can die, save by God's leave, at a term pre-ordained" (3:145). Halim, on the other hand, disagrees with his older brother arguing that it is not right to allow their father to suffer by artificially prolonging his life. While Halim certainly does not want to see his father die, he nevertheless feels that it is important to consider the ethical issues associated with maintaining the terminally ill in hospitals. Halim is well aware that every year hospitals spend billions of dollars to keep patients alive in a vegetative state in intensive care units. For Halim, an act of true Islamic piety would be to end his father's suffering and let him die peacefully by withdrawing the respirators, and freeing up funds for patients with greater chances of recovery. Ahmad's wife listens to arguments presented by both her sons, but is at a loss over what to do.

#### Notes:

The issue of end-of-life care is a controversial one within Muslim circles. This has much to do with a particular verse within the Koran that states that "...no human being can die, save by God's leave, at a term pre-ordained" (3:145). Many Muslims have interpreted this particular verse to suggest that a patient cannot be taken off life support, as this action is akin to a form of assisted suicide, which is strictly forbidden in Islam. In this particular case study, however, the issue is compounded by the fact that the patient Ahmad, has no living will, and has been in a coma for four months with very minimal brain activity. The question that respondents must negotiate now is how long this particular patient is to be kept on life support, at what financial cost, and how their personal understanding of end-of-life according to Islamic precepts plays into the scenario.

#### Summary of Responses:

Similar to the first case study regarding abortion, we found that respondents to this question fell into one of three camps. First, are those respondents who felt that it

was absolutely against Islamic law to remove the patient from life support. Second, are those respondents who felt strongly that Islamic law would permit removal from life support, and third, are those respondents who felt that the issue needed to be addressed from a personal position of piety and intellect, and not a broad all-encompassing Islamic prescription.

Respondents who felt that the patient should be taken off life support, pointed out such factors as the “un-Islamic” act of keeping a human being alive in a vegetative state, that such an action is “disrespectful to the body” and that the Koran does not mention anything about keeping people alive on artificial respirators, and as such, their removal from them does not break with Islamic law. Interestingly, several participants who argued for the removal of life support suggested that the very act of placing someone on life support itself can be seen as an act of “playing God,” and as such, perhaps the act of placing a Muslim patient on a ventilator should be prohibited from the beginning. By not placing a patient on a ventilator, families are allowing nature to take its course and, as some participants argued, they would not be faced with the predicament of removing life support, and the consequences that such an act would carry.

Moreover, out of those respondents who felt that it was permissible to remove the patient from life support, several pointed out that it was “more Islamic” to allocate funds aimed towards artificially saving somebody towards individuals that have a better chance of survival.”

Roughly one-third of respondents felt that the patient should be kept on life support. On this point, some participants felt that, according to their belief system, if the patient has even a one percent chance of survival (or of waking from a coma), then it is necessary to maintain measures of life support. Because it is almost impossible to eliminate that one percent chance then, almost all Muslim patients in this particular state must remain on life support. Participants that responded in favor of life support cited many examples of patients, whom they personally knew, that were in

comas on life support and that re-awakened after some time. They felt that these examples illustrated the belief that only God would decide when a person would die.

In the final categorization of responses were those who felt that cases should be judged, guided by rational thought. These particular respondents felt that it was important to take a more humanistic ethical stance on the position of end-of-life life support removal. According to some participants within this group, it is ultimately up to God when life is to end, but it is an individual and personal decision as to what route to take towards this end.

What most respondents did agree on, however, was the position that either way, the decision to remove someone from life support is a morally and ethically challenging prospect. Some felt that ethically, the patient should be removed from life support, but that morally it was nevertheless a difficult decision to make. Other respondents felt that keeping someone on life support was akin to torture, whereas removing life support was issuing someone's death. Either way, the decision is a difficult one to make. Also agreed upon by almost all participants was the important role that ones religious faith and belief system plays in such end-of-life scenarios.

Additional points that were made include:

- a) Concern with doctors and healthcare practitioners not being patient enough with families when it comes to making this type of decision. People in the healthcare field should be more cognizant of the difficulty behind making such decisions, particularly for Muslims.
- b) The importance of leaving a will, or directive for family members and sharing your wishes with friends and family.

#### **Additional Notes:**

When a patient has just died in a hospital, or is just in the process of dying, the body is sometimes folded according to Christian style. According to Islamic principles, however, the arms should remain straight next to the body, and all tubing should be

removed. There have been instances when bodies have been delivered to the funeral home with tubing still inserted in the body. When the patient is deceased, staff should take careful measures to move the body so that their feet are facing kaaba, and that the body is laid on its right side. Perhaps it would be nice if nursing stations had a compass on hand.

### **Islamic bio-ethics Perspective:**

It is nearly impossible to ascertain so-called “Islamic” positions on particular areas of healthcare without understanding the complex nature of what constitutes “Islam.” While this conversation would take us out of the scope of the current conversation, it would suffice to say that there exists no “singular” perspective on many of these healthcare positions owing to the rich and diverse nature of Islamic law, together with the influences of local cultural histories and traditions on these laws. As such, to parse out a singular Islamic “position” on a particular healthcare question becomes a momentous task.

Adding to the difficulty of trying to define what constitutes “Islam” is the associated difficulty in defining what precisely “Islamic bio-ethics” constitutes, and who, or what groups exactly speak for it. They are questions that increasingly are being debated worldwide with entire conferences dedicated to their discussion. Comprehensive discussion of these questions lies outside the parameters of this current study, but a few brief points will help contextualize following discussions.

According to Ghaly (2015), the religio-ethical debate in Islam began a renewed movement in the 1980s. During this period, medical, scientific, and religious scholars began to recognize the importance of establishing tangible guidelines for medical ethics in Islam.<sup>ii</sup> The creation of fiqh academies (loosely, centers for the study of Islamic law), and conferences enabled Muslims to begin a robust discourse on issues pertaining to Islamic bio-ethics.

## Collective Religio-Ethical Reasoning

- 1977 – Islamic Fiqh Academy (IFA), Mecca
  - 1981 – International Islamic Fiqh Academy (IIFA), Jeddah
  - 1981 – First International Conference on “Islamic Medicine”
  - 1983 – Initiating the series “Islam and Contemporary Medical Concerns” via conference titled “Human Reproduction in Islam”
  - 1984 – Islamic Organization for Medical Sciences developed
- (Adapted from Ghaly, 2015).

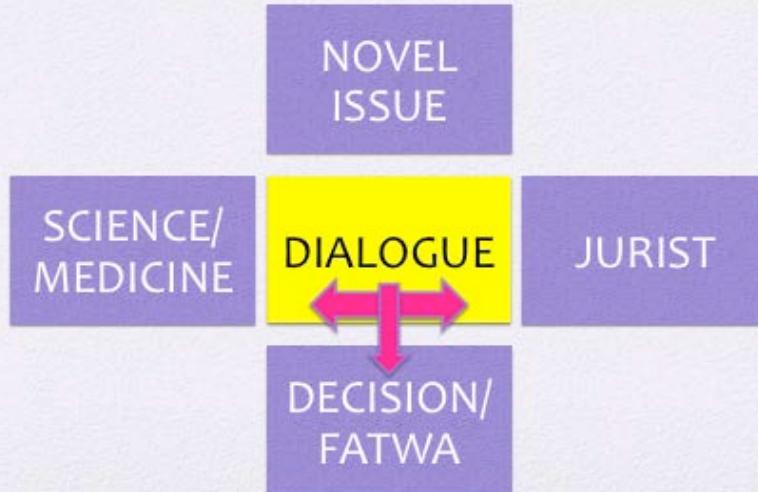
Dominating much of the discourse, naturally, was how exactly decisions pertaining to Islamic bio-ethics were to be reached. As Kasule (2015) indicates, the sources and processes necessary for the task, have shifted overtime. For instance, Kasule has outlined the following stages in the evolution of Medical fiqh (law):

- Period 1 (0-circa 1370H) – Sources derived from the Quran and the Sunnah (sayings and deeds of the Prophet Muhammad)
- Period 2 (1370-1420) – the rise of novel medical issues arising from changes in medical technology necessitated the use of secondary sources of law. These came in the form of qiyas (analogy), ijma (consensus), or istihsaan (rational thought).
- Period 3 (1420H - Onwards) – Theory of Purposes of Sharia (Maqasid al Shari'at)<sup>iii</sup> and Ijtihad (independent reasoning, often used in conjunction with qiyas or ijma).

Where Islamic bio-ethics tends to differ from other Western models of bio-ethics is in the direction of the decision making process. This has much to do with the nature of the Islamic belief system itself—as a unified system where morals are viewed as eternal truths and not human ideas, and where the concept of Islam itself is synonymous with ethics. So whereas in contemporary ethics practices often the decision process begins from the discipline and moves towards ethics, in Islamic bio-ethics, the decision begins from the guiding principles and those principles, in turn, inform and shape the discipline (Alaszri, 2015).

Of course, guiding principles require interpretation and analysis and this leads us to question, who speaks for Islamic bio-ethics? In theory, when a novel question arises a deliberation takes place between the scientist and/or medical professional and a qualified jurist. The jurist will refer to appropriate sources and engage in the aforementioned process of decision-making processes and come to a decision on the issue. With the rapid growth of the Muslim community, and the proliferation of new medical technologies, however, we have begun to see the emergence of large Islamic bodies committed to addressing medical/bioethical issues. These institutions encourage, in large part, increased dialogue between the realms of science and medicine and Islamic theology in order to make new medical technologies available to patients whilst ensuring that they do not transgress Islamic ethics.

## Islamic Bio-Ethics



Just as there is no singular “Islam,” however, there also does not exist a singular type of “Islamic bioethics.” While all decisions are rooted in Quranic edicts and the Sunnah, processes of ijtihad and qiyas, combined with cultural norms often give way to a variety of opinions on a singular topic. As this body of research illustrates, at the macrolevel there exist strong opinions on certain topics (for instance, abortion is not ideal, suicide is not permitted, etc). The minute details below these umbrella proclamations, however, often can yield diametrically opposed positions, revealing a fascinating snapshot of a diverse faith tradition.<sup>iv</sup> In the following section we will provide an overview of three medical issues, and the various Islamic perspectives surrounding them.

### Issue 1) Abortion

Similar to a vast number of other medical issues, the topic of abortion is not specifically mentioned in the Quran, but scholars and jurists have based many of their decisions on the matter on related matters that *are* discussed in the Quran. For instance, the Quran is quite clear as to its position on the sanctity of life:

“Whosoever has spared the life of a soul, it is as though he has spared the life of all people. Whosoever has killed a soul, it is as though he has murdered all of mankind” (5:32).

Alternately, the Quran also states that economic hardship is not an excuse for terminating the lives of offspring:

“Kill not your offspring for fear of poverty; it is We who provide for them and for you. Surely, killing them is a great sin” (17:32).

When extrapolated towards the issue of abortion, jurists often cite these two Quranic proclamations as evidence that it is not, in general terms, a preferred practice.

This said, however, underneath the broad opinion against abortion in general terms, lies minute rulings guiding its practice. As the chart below illustrates various schools of jurisprudence (in this case Sunni schools) allow for abortion within certain parameters.

Hanafi	Abortion permitted until 120 <sup>th</sup> day
Hanbali	Abortion permitted until 40 <sup>th</sup> day
Maliki	Abortion permitted until 40 <sup>th</sup> day
Shafi'i	Abortion permitted until 120 <sup>th</sup> day

All of our research indicates that all four schools of Sunni jurisprudence allow for abortion should the pregnancy threaten the mother's life. Moreover, all four schools agree to some extent that abortion is also permissible if the fetus is extremely deformed or defective and will not, if carried to term, have quality of life. The issue that becomes a point of contention, however, is how "extremely deformed or defective" and "quality of life" are determined, as these can be quite subjective terms. Nevertheless, all jurists are in concurrence that the abortions must be performed before the period of ensoulment (when the spirit [ruh] enters the fetus). They vary, however, as to when this ensoulment takes place with some schools arguing that it occurs on the 40<sup>th</sup> day, while others suggest that it is more around the 120 day mark.

Alternative perspectives:

More recently, the Ayatollah Khameni of Iran issued a fatwa permitting abortion of fetuses under ten weeks that have apparent signs of the genetic blood disorder thalassemia. Also breaking with traditional Sharia law, Iran's Grand Ayatollah Yusuf Saanei issued a fatwa essentially permitting abortion within the first 90 days of a pregnancy within certain parameters. While acknowledging that abortion is, customarily forbidden in Islam he continued to proclaim that,

"Islam is also a religion of compassion, and if there are serious problems, God sometimes doesn't require his creatures to practice his law. So under some conditions—such as parents' poverty or overpopulation—then abortion is allowed" (Saanei, 2000).

More recently, some jurists have begun to entertain the permissibility of abortion for social reasons as well. As Albar (1991) points out, jurists have issued fatwas in favor of abortions where the child was conceived as a result of rape, where the pregnancy would have a detrimental affect on a nursing child, or if provisions could not be made for sustenance of the unborn child. (As an example, the Zaidi school of jurisprudence allows abortion for social and minor medical reasons within the first 120 days of conception [Albar, 1991]).

In the course of our research we have also come across fatwas that permit, for instance, the abortion of a fetus determined to have conditions such as Down Syndrome or Spina Bifida. In a recent ruling, Egypt's Dar Al-Ifta Al-Misriyyah Institute (an educational and governmental center for Islamic legal research) issued a statement declaring that,

"It is permissible in Islamic law to have an abortion before 120 days of pregnancy if the physicians determine the presence of fetal deformity...Moreover, there is no objection in Islamic law to conducting the necessary tests to check for such incurable diseases and congenital defects" (Dar-Al-Ifta Al-Misriyyah, 2015).

It is clear then from this brief analysis of perspectives that Muslims continue to debate the parameters of what constitutes "ethical abortion." What the community

does appear to agree on, however, is that abortion is not an ideal practice. When, and under what conditions the practice can take place, however, are open to a variety of interpretations.

For Health Care Practitioners:

- ➊ It is important to broach the issue of abortion with Muslim patients with a great deal of sensitivity, as it can be a highly contentious subject.
- ➋ Familiarize yourselves with the concept of ensoulment and recognize that not all Muslims are in agreement as to when ensoulment of a fetus takes place
- ➌ Encourage the family to seek guidance from their spiritual leader
- ➍ Upon abortion, many Muslim families will wish to bury the fetus according to Islamic traditions. These include saying a prayer in the ear of the fetus, shrouding the body in a cloth and conducting an Islamic burial ceremony.
- ➎ Ensure that parents have access to mental health help following an abortion, but provide the option with great sensitivity, as the acceptance of mental health assistance is an area that is still evolving amongst Muslim societies.

## Issue 2) Stem Cell Research

Doctors have been performing bone marrow stem cell transplant for decades, but the realization that stem cells could be harvested from human embryos is a relatively new phenomenon (1998). The ability to harvest these stem cells and use them to cure diseases (in short, stem cell research has the potential to replace specialized human cells [and be extension organs] by developing new cells from human embryonic stem cells or hESCs, for short) caused a great deal of excitement. Those who quickly drew attention to the moral implications associated with

destroying human embryos, however, tempered the enthusiasm. Stem cell research raised some crucial questions, including:

- At what point does human life begin?
- What rights, if any, does a human embryo have?
- Does the destruction of a human embryo justify the potential cure that it can provide for numerous patients?
- Is the embryo truly being destroyed if, in theory, embryo stem cells can continue to grow in a dish?

These questions are the very same ones that continue to fuel the stem cell research debate within Islamic circles. It remains that the crux of the debate surrounding stem cell research in Islam is the inherent tension between the dual obligations of respecting human life, whilst at the same reducing suffering and pain.

#### Muslim Perspective:

There generally tend to be two leading schools of thought when it comes to stem-cell research in Islam. On the one hand, there is the opinion that since the early embryo is not fully formed, and cannot survive outside the womb, then obtaining stem cells from it is permissible. Individuals subscribing to this ideology are strong proponents of the belief that the possibility of curing/aiding a living being justifies the destruction of an embryo. Not only do they believe that it is acceptable, they also see it as a duty.

On the other side of the debate are those who believe that the embryo has the full status of a being, with all the rights accorded to it under religious law. According to this view, “any technology that involves creating dispensable embryos, including the provision of replacement cells” is rejected (Aksoy, 2005).

The driving force behind this debate continues to be the question of whether or not un-implanted embryos are considered living beings, and whether or not their use for biomedical research is considered Islamically “ethical.” As with other

contemporary medical issues, there are no specific Quranic edicts, or hadiths (narratives of the Prophet Muhammad) that specifically address the issue of stem cell research, so jurists have had to extrapolate from alternative rulings and Quranic injunctions to address the issue.

For instance, as stated in the previous section, ensoulment in Islam, begins at the time when the physical fetus is joined with the spirit (ruh). According to the Koran, "...He is the Mighty One, the Merciful, who excelled in the creation of all things. He first created man from clay, then made his offspring from a drop of humble fluid. He then molded him and breathed into him of His spirit..." (32:6-9).

Many jurists have interpreted this verse as a differentiation between biological life (which begins at the point of fertilization) and human life (which begins at the point of ensoulment, and "confers moral status on the fetus" [Tuell, 2011]). The question then becomes (as previously discussed), when exactly the period of ensoulment occurs, and if harvesting of embryos after the period of ensoulment transgresses Islamic principles.

According to our research, most Islamic jurists consider un-implanted laboratory embryos to be these former "biological" lives, distinct from "human lives" and as such, there are no real moral barriers to their use for biomedical research (Sachedina, 2009). In fact, far from being unethical, the endeavor to find and provide cures for human diseases is considered a "collective moral obligation on the world's Muslim community" (Tuell, 2011; Sachedina, 2009) as exemplified by the following hadith:

"The Messenger (PBUH) ordered us to seek cure for disease: Allah created disease and treatment, and He made for each disease a treatment. So seek treatment but do not use haram (forbidden things)"<sup>v</sup> (Sunan Abi Dawud).

Building upon this principle, numerous high-profile Muslim jurists and scholars have endorsed the practice of stem-cell research. Renowned scholar Abdulaziz Sachedina, for instance, has stated that:

“Research on stem cells made possible by biotechnical intervention is regarded as an act of faith in the ultimate will of God as the Giver of all life as long as such an intervention is undertaken with the purpose of improving human health”  
(Sachedina, 2000).

The use of stem cells, however, does come with some caveats. For instance, during a recent 2003 conference in Mecca, the Muslim World League’s Islamic Jurisprudence Council issued a fatwa regarding stem cell research, stating that:

“It is permissible to use stem cells for either legitimate scientific research or for therapy as long as its sources are legitimate . . . adults if they give permission as long as it does not inflict harm on them; children with their guardian’s permission for a legal benefit without inflicting harm on them; placenta or umbilical cord blood with the permission of the parents; spontaneously aborted embryos or those aborted for a legally acceptable cause and with the permission of the parents; excess fertilized eggs produced during the course of IVF and donated by the parents with the assurance that they are not to be used to produce an illegal pregnancy.”

Additionally, the fatwa added that:

“It is forbidden to obtain or use stem cells if its source is illegitimate as, for example, intentionally aborted fetuses (abortion without a legal medical reason); [and] intentional fertilization between donated ovum and sperm...” (Muslim World League, 2003).

In a similar vein, the ethics committee of IMANA, (the Islamic Medical Association of North America), recently stated that as part of their inquiry into the practice of stem cell research, most scholars “opined that embryonic stem cell research using surplus pre-embryos produced during the course of IVF performed for infertility patients is

permissible with the consent of the couple.”<sup>vi</sup> The limitation to this practice, however, is the prohibition “to create these pre-embryos for the sole purpose of research” (IMANA, 2016).

In gathering evidence and data from leading Islamic scholars and jurists around the world on the topic of stem cell research, the Islamic Medical Association of North America has issued its own statement on the practice. In concluding their findings they have stated the following:

- In principle, stem cell research, including the use of hESCs, is acceptable due to its therapeutic potential.
- Fertilized eggs before implantation are not considered fully human because without implantation they cannot survive and develop into a human being.
- The supernumerary embryos produced during IVF cannot be donated to other couples and if the same couple will not use them, they will have to be destroyed or left to die. Using them for stem cell research in this case is, at a minimum, acceptable and may even be preferred over their destruction.
- Islamic scholars agree that creating human embryos for the sole purpose of research is prohibited (IMANA, 2016).

For Health Care Practitioners:

- ➊ Familiarize yourself with the Islamic position on stem-cell harvesting and research.
- ➋ Ask questions from patients and family regarding their position on stem cell research. As it is a relatively new and complex issue, take time to explain it to them in detail, and with accessible language. Explain the position aspects of stem-cell donation.

- ➊ Provide support for families with whatever decision they make
- ➋ Use a great deal of sensitivity when broaching the issue of stem cell tissue donation of a spontaneously aborted fetus keeping in mind Islamic positions on death and dying.

### Issue 3) End of Life Decisions

Perhaps moreso than the previous two case studies, issues relating to end of life<sup>vii</sup> are the most difficult to address both from the perspective of adherents, and those of healthcare providers. As is evidenced by current debates taking place in Canada regarding end of life issues, the case is a sensitive one that requires nuanced attention to varied perspectives. Adding a religious dimension to the arguments adds to the complexity of the situation as now, we are not just concerned with actions that can be equated with “playing God,” but also with how such actions may affect ones moral and spiritual realities. The meaning of suffering and end of life issues are perceived in a variety of ways by Muslims depending on a host of factors including family values, cultural background, societal norms, and levels of education. Generally speaking, however, Muslims are taught to accept death as part of their journey—the end of a very temporary worldly life, which is to be followed by an ultimate spiritual afterlife. Death is viewed as a natural part of the lifecycle; yet, Islam urges at the same time the importance of recognizing the sanctity of life. It is this duality between the preservation of life and the acceptance of death as the will of God together with notions of suffering that have formed the basis of much of the end of life debates within Islamic circles.

As with the previous two scenarios of abortion and stem cell research, there exists no singular response to the question of termination of life within Islamic legal spheres. Somewhat different, however, from the previous case studies is the fact than the Koran is not necessarily silent on the matter of end of life. As such, many of the positions on end of life termination are formed on the basis of scripture, and various interpretations of it. For instance, the basis of many discussions

surrounding the question of end of life decisions in Islam is rooted in Quranic discussions of life as a sacred trust from Allah (God): and that only God can determine the span of one's life:

"Slay not yourselves. Surely Allah is ever merciful to you" (4:29)

"Nor can a soul die except by Allah's leave, the term being fixed as by writing" (39:42)

"No person can ever die except by Allah's leave and at an appointed term" (Koran 3:145).

"When their time comes they cannot delay it for a single hour nor can they bring it forward by a single hour" (Koran 16:61).

How these proclamations, however, inform end of life decisions are varied. On the one hand there are those who believe that euthanasia and dysphasia are strictly forbidden. Those subscribing to this position argue that only Allah can determine at which time a person will die, and that humans are not to make such executive decisions (in essence, playing God).<sup>viii</sup> As part of this perspective, the onus is on the health-care provider to do everything in their power to prevent death, including resuscitation, and the prolongation of life for patients in comas. In terms of euthanasia, the majority view tends to be that a patient cannot take his/her own life, owing mostly to the Quranic injunctions against murder and suicide:

"And do not kill yourselves, surely God is most Merciful to you" (4:29)

"Do not throw (yourselves) with your own hands to destruction but work (deeds of) excellence for verily Allah loves the people of excellent" (2:195)

and

"Whoever kills a soul-unless for another soul or for corruption—it is as though he slew mankind altogether" (5:32).

At the same time, the patient must exercise patience and have faith in the face of adversity: "Oh you who believe! Seek help in patience and prayer. Truly God is with the patient" (Sura 2:153-57).

In fact, some Muslims see the act of practicing patience and enduring poor health as a way of atoning for sins—their poor health is attributed to the will of God and they must be resilient and patient as God tests their will:

"We shall test your steadfastness with fear and famine, with loss of life and property and crops. Give good news to those who endure with fortitude; who in adversity say: 'We belong to God, and to Him we shall return.' On such men will be God's blessing and mercy; such men are rightly guided" (2:154-156).

A similar hadith attributed to the Prophet Muhammad also states:

"No fatigue, nor disease, nor sorrow, nor sadness, nor hurt, nor distress befalls a Muslim, even if it were the prick that he received from a thorn, but that Allah expiates some of his sins for that" (Sahih al-Bukhari, 2016).

It is clear from these above discussions that the termination of life, whether actively (through euthanasia) or passively (withholding care), is something that many Muslims are in stark opposition to. In fact, as earlier indicated in our own research with members of the community, some believe that as part of their religious doctrine, a life should be kept at all costs and with all measures. This perspective, however, is being challenged by some leading authorities who are providing some nuanced direction in certain end of life matters.

#### Withholding Treatment:

According to Sachedina (2005), there are moments of passive assistance that would allow a patient to die, and that would be considered permissible by Islamic law. For instance:

"Administering analgesic agents that might shorten the patient's life, with the purpose of relieving the physical pain or mental distress, and withdrawing a futile

treatment in the basis of informed consent (of the immediate family members who act on professional advice of the physicians in charge of the case), allowing death to take its natural course.”

In some cases, treatment will not change the outcome of a patient’s situation. When their quality of life is compromised extensively, some jurists have suggested that the elimination of suffering takes precedence over prolongation of life. For instance, jurist Shaykh Al-Qaradawi has stated that:

“...preventing the patient from his [or her] due medication, which is from a medical perspective thought to be useless, this is permissible and sometimes it is even recommended. Thus, the physician can do this for the sake of the patient’ comfort and the relief of his family” (2009).

Qaradawi does not view the withholding of medication as a form of active euthanasia. Rather he suggests that the act is “different from the controversial euthanasia or mercy killings as it does not imply a positive action on the part of the physician; rather it is some sort of leaving what is not obligatory or recommended, and thus entails no responsibility” (2009).

Alternately, the Islamic Code of Medical Ethics, issued by the First International Conference on Islamic Medicine in Kuwait stated that “...If it is scientifically certain that life cannot be restored, then it is futile to diligently keep the patient in a vegetative state by heroic means or to preserve the patient...by artificial methods. It is the process of life that the doctor aims to maintain and not the process of dying” (2008).

Where the patient is determined to be brain-dead the jurists ruled that “if three attending physicians attest to a totally damaged brain that results in an unresponsive coma, apnea, and absent cephalic reflexes, and if the patient can be kept alive only by a respirator, then the person is biologically dead, although legal

death can be attested only when the breathing stops completely after the turning off of life-saving equipment" (Sachedina, 2005).

This sentiment has been echoed by numerous other jurists as well, including Dr. Muzzami Siddiqi, former president of the Islamic Society of North America, who has stated that, "If the patient is on life support, it may be permissible, with due consideration and care, to decide to switch off the life support machine and let nature take its own time" (Siddiqi quoted in Aramash and Shadi, 2007).

Thus it is evident through an examination of these varied perspectives that there exists a spectrum of opinions when it comes to the matter of Euthanasia, DNR, and dysthanasia. Generally speaking, however, we can conclude that while majority jurists agree that while suicide and assisted suicide are strictly forbidden in Islam, there are a growing number of jurists that also make room for the withdrawal or withholding of medical treatment should it be in the best interest of the patient, and within certain preset parameters. As our research with focus group participants indicates, however, not all Muslims necessarily subscribe to this latter perspective.

For Health Care Practitioners:

- ➊ Familiarize yourself with the Islamic position on end of life care, euthanasia and assisted suicide
- ➋ Encourage patients to have a living wills and advance directives
- ➌ Ask families about any cultural or religious beliefs that they may have regarding end of life decisions.
- ➍ Recognize that from a cultural perspective, end of life decisions may be made by the elder, male members of certain families. In some situations, it is the elder male in the family who will request to be present at the time that treatment is being terminated.

- ➊ Be thorough in your explanation of the patient's medical situation with the family. Clearly communicate with them what the patient's expected outcome is to be so that families can make informed decisions.

### **Concluding Remarks:**

In speaking with our Muslim interviewees we got the sense that, overall, they were quite happy with their interactions with the Canadian medical system. For the most part they felt that healthcare practitioners respected their wishes, tried their best to communicate matters with them, and tried to make concessions where necessary. There was also the general sense that the Muslims we spoke to did not feel that they were in any way discriminated against as a result of their cultural/religious background. It was noted that, interestingly enough, this had much to do with the shifting demographics of medical professionals themselves (with many more visible minorities working within the healthcare area).

What was also interesting was the generational gap that became evident during the course of our interviews. Younger members of the Muslim community seemed much less preoccupied with issues such as having same-gender doctors, with privacy issues in hospital settings, or with any language barriers.

We had anticipated prior to conducting our research that when seeking answers to religious questions concerning healthcare, most Muslims would turn to their local Imams. Interestingly enough, however, it appears that a growing number of Muslims are now turning to the Internet (either various websites or online fatwas) for answers to healthcare questions. This use of technology may indicate both the prevalent use of technology, especially amongst the younger generation, as well as less reliance on the local mosque, and by extension the Imam, for guidance on issues outside central tenets of belief. To this point, it is worth emphasizing the expressed

desire on the part of some participants for a central website that could operate as a general resource guide for Islamic positions on healthcare questions.

The second section of our research project focused on case studies that dealt specifically with Islamic sensitivities to varied health care scenarios. As we had anticipated prior to conducting the interviews, the responses that we received to these scenarios were diverse and reflective of a variety of opinions and positions. This type of finding should not be taken lightly. It represents a central theme in Islam, and in any research dealing with the Islamic faith—that there is no singular Islam, and by extension, no singular position on almost any one thing associated with the faith. Rather, the responses that we received are a reflection of a variety of factors, ranging from cultural proclivities, to educational backgrounds, to family dynamics all coalescing into varied interpretations of faith. And it is precisely the interpretation of faith that ultimately guides many of the healthcare decisions that continue to be made by Muslims on a daily basis—interpretations of faith that mould the varied positions posited by jurists and scholars alike—all indicative of a robust and dynamic faith system. The final section of our research reveals with full clarity this dynamism as evidenced by the varied positions on a singular healthcare question. From determining the exact moment that a fetus becomes a human to the precise moment that an individual can relent the will to live—the rich canvas of responses to these varied questions can be at once a source of frustration as well as a source of comfort. It thus becomes more so imperative for healthcare professionals to educate themselves towards these cultural nuances—at least to the extent that they recognize the very basic issues facing Muslim patients, so that they can better help patients and their families negotiate what can sometimes be a traumatic and intimidating terrain.

### **Future of Islamic Bio-Ethics and Healthcare:**

Research into Islamic bio-ethics has increased dramatically in the past decade, owing in large part to new medical technologies that have necessitated new discourse. As several scholars have suggested (Alazri, 2015, Kasule, 2015, Misha'l,

2015), the use of Qawaaid (guiding principles) in establishing ethical standards is crucial, but there is a need for ijtihaad (independent reasoning) for more detailed applications. Consultations between religious and scientific scholars are helping raise and resolve pertinent bio-ethical issues, and conferences and seminars among these groups are becoming more prevalent. As Misha'l (2015) points out, such "organized interactions have become a cornerstone in contemporary Fatwa and Sharia opinion."

And never has this interaction been more vital, as the area of healthcare and Islamic principles is a burgeoning field--particularly in three key areas. These are; the nexus between Islamic belief and new health care technologies, women and healthcare (including reproductive technologies), and mental health. Issues pertaining to women, and mental health are particularly interesting as these are two areas that, until recently, have received very little attention due to cultural barriers. With ever-shifting cultural boundaries, increased education and globalization, however, addressing these issues is not only becoming more acceptable, but also more imperative.

This particular study was based on a small sampling of a cross-section of Muslim in Edmonton: a fact that in itself raises a final point of discussion, which is the need for a national perspective on these various issues. Given the diversity of the Islamic community, together with its divergence of opinions, there will no doubt be some who would suggest that our findings are not reflective of all positions, or even the "correct" position. This is not a new criticism for many studies focusing on residents of a multicultural nation. Because our participants come from a variety of backgrounds, culturally, ethnically, and linguistically, our findings may vary from an equivalent study performed in a more religiously, and culturally uniform location. What this ultimately suggests is that there is a need for a national discourse that is more attuned not only to the differences of its Muslim population, but also to current Canadian healthcare issues. A recent Supreme Court of Canada decision that

would make designated cases of doctor assisted suicide legal, for instance, may raise some interesting questions regarding the Canadian-Islamic position on doctor assisted suicide.

### **Study's Limitations**

The author's wish to acknowledge with great appreciation the contributions made by the focus groups and the Muslim participants who offered their viewpoints. We do, however, want to reiterate that this is a very basic study of a very contemporary and complex area. This feature is no more evident than in the few cases highlighted here.

Our research has indicated major fields of discourse yet to be plumbed: issues around surrogate motherhood, artificial insemination and various other intervention techniques of pre-birth, such as sperm donor clinics; major replacement therapies, including challenges to the notion of God controlling all of life such as we find in heart transplants, etc.; the use of artificial intelligence data for therapeutic purposes; the procuring of organs for transplant purposes; experimental cell modifications for therapeutic activities; programmable behavioural modifications; mental health and mind interventions, etc. Health care professionals need to know what the parameters of many of these therapies are since they may eventually have to deal with them.

This pilot study has shown that the area is a rapidly developing one requiring consolidated and vigorous participation by Muslims of all groups so that the future will, at the very least, have some guidelines in place. This participation, however, has exemplified one of the largest limitations to this study—the reluctant participation of many Muslims for this type of study. It is our opinion that there exists a widespread personal concern not to speak on behalf of an entire population, and that this concern may have had an impact on the views that eventually were expressed. We believe that these concerns may also explain our inability to attract any input from Muslim physicians. It remains, however, that given the strict anonymity promised to participants, we still have no convincing reason as to why

we were so unsuccessful in recruiting those within the healthcare industry to participate in this study. With respect to the participants in this study, another glaring limitation, of course, was that our sample size (while diverse both along gender lines and amongst the Muslim communities in Edmonton) was, nevertheless, small in size. Given the small sample size we did not find it statistically significant to screen for age. We are confident that the majority of our respondents were middle-age, with those under the age of 35 comprising perhaps 4-5 individuals. That we did not get a very strong turnout of younger Muslims proved a great dearth to this study as there appear to exist, (as revealed by several of the comments heard during the course of the interviews), large generational differences in approach to Islamic healthcare.

Another limiting factor to this study may be the city in which it was conducted. Edmonton, Alberta is home to one of the oldest Sunni mosques in Canada and the city has a very well established and long standing Muslim community. Muslims in the city are fairly well integrated, and are widely present within healthcare fields. In this respect, Edmonton may not be representative of other Canadian Islamic experiences where the community may not be as well integrated or established.

As evidenced in this body of research, a number of issues remain unresolved, as they continue to remain unresolved in Canadian society. We wish to encourage Canadian Muslims to engage in open discussion about the issues raised by this study, and furthermore to enter into dialogue with both health professionals and the larger community. In an area with few answers, it seems imperative that sensitivity to Muslim tradition should have its place in these developments.

## Appendix 1: Lessons for healthcare givers in hospital settings

### SAME-SEX DOCTOR

The necessity of a same-sex doctor, however, is not one that is agreed upon by all Muslims. Indeed, many of the Muslims that we interviewed felt that rules pertaining to modesty and/or hijab are exempt when dealing with issues of healthcare, and that receiving treatment from a capable person trumped receiving care from someone of a particular gender. Muslim men or women MAY request a healthcare provider of the same gender. This may be done for religious and/or cultural positions pertaining to modesty and hijab (the covering of oneself from the opposite sex). If this request cannot be fulfilled, it is important this is clearly communicated to the patient, and if possible to have another healthcare provider of the patient's gender (or a family member of the same gender) present during the delivery of care.

### HIJAB

During clinical examinations, healthcare providers should try to limit physical exposure of the patient to the degree possible, once again owing to the religious/cultural positions on modesty. A Muslim woman may choose to observe hijab during her stay in the hospital (wearing traditional Islamic coverings), and HC providers should try to respect this to the degree possible. At some hospitals, patients request a sign to be hung from the door requesting that people knock before entering so as to give them time to ensure that they are properly clothed.

### FOOD

Muslims are prohibited the consumption of certain foods, including alcohol, pork and pork derivatives (lard), and meat products that are not halal. The extent to which these laws are observed, however, vary according to individuals. As our interviews indicate, certain individuals felt that the consumption of certain "non-Islamic" entities were permissible if they were for medicinal purposes. These would

include such items as cough syrup (that has alcohol in it), gelatin capsules (derived from pork), and such. According to some sources, the intake of prohibitive foods is permissible for Muslims under extraordinary circumstances (Salman, 2010).

The majority of participants, however, felt that if there existed alternatives to these items (such as non-capsule tablets), then they would be required to consume those instead. It is important for HC practitioners to notify patients (where possible) about the ingredients in medication, and about alternatives (where available) to the medications. The patient can then make an informed decision that would align with their faith traditions.

For patients staying at hospitals there is also the issue of halal food. As mentioned, many Muslims choose to consume only foods that are halal. Increasingly, many hospitals are now beginning to offer halal and kosher dietary foods to their patients, but where this option does not exist, some patients may choose to eat only vegetarian dishes, or food that is brought to them from outside the hospital. It is important for healthcare staff to be aware of these dietary restrictions and to assist where possible to make sure that the patient is receiving adequate nutrients in their modified diet.

The other related issue to food consumption is that of Ramadan, the month of fasting for Muslims. As part of their faith, Muslims are required to fast during the month of Ramadan, given that they are physically capable of doing so. Health care practitioners may need to discuss the issue of fasting with the patient if they feel that it may interfere with their health and/or recovery. According to many sources of Islamic law, fasting is not obligatory if it interferes with one's health, however, this position is open to much interpretation. Very observant patients may be hesitant to break the fast, so communicating the consequences of continued fasting on their health much be communicated to them in detail.

## Appendix 2

Waugh / Razavy "Muslim Spiritual Realities"

### Focus Group Sample Questions – MEDICAL PROFESSIONALS

- 1) As a Muslim medical practitioner do you have many Muslim patients who choose to see you because of your cultural background?
- 2) As a Muslim doctor, what can you offer to your Muslim patients, that perhaps other doctors of non-Muslim backgrounds, cannot?
- 3) Have any of your Muslim patients ever requested a particular gender of doctor due to religious beliefs, and have you always been able to accommodate them?
- 4) Have patients ever come to you with questions regarding particular medical processes and their compatibility with the Islamic faith?
  - a. Islet transplants
  - b. Organ transplants
  - c. Fertility issues
  - d. Stem cell research

(Can you please discuss each case separately). If so, how do you broach these questions?

- 5) Have you ever been asked for advice by Muslim patients/families when faced with end of life decisions? If so, how do you respond?
- 6) Do you, as a Muslim doctor feel the need to present alternative solutions to certain situations (for instance, certain medications that may contain pig gelatine, or alcohol) for Muslim patients?
- 7) What barriers, if any, do you feel exist when it comes to the delivery of healthcare to Muslim patients? For instance, are language and/or gender pressing issues?
- 8) Do you, as a health care practitioner, witness what we would refer to as issues of gender dynamics amongst your Muslim patients? For instance, are your Muslim female patients comfortable with discussing their issues with you directly, or do they typically have a male family member with them who will partake in conversations? (not necessarily due to language concerns, but more due to cultural issues of gender hierarchy/dynamics). Are there issues that you feel Muslim female patients do not feel comfortable discussing with you?

- 9) When this project is completed we will have gathered a large amount of data pertaining to Islamic positions on various medical procedures, together with reflections from both members of the Muslim community as well as medical professionals regarding interactions within the health care system. In your opinion, what format would you find most valuable for the delivery of this type of information. For instance, would you be interested in having this information available for easy referral in the form of a website, a handbook, etc?
- 10) How do you counsel Muslim patients who may be sick and are concerned about their religious obligation to fast during the month of Ramadan?

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## Notes

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<sup>i</sup> On this point, please refer to the note under the limitations section on generational differences and age factors in this study.

<sup>ii</sup> It is worth noting the Saudi origin of these initiatives.

<sup>iii</sup>According to Kasule (2015), *Maqasid al shari'at*, comprises the 5 purposes of Sharia and should drive medical bio-ethics. These are: “preservation of religion and morality, *hifdh al ddiin*; preservation of life and health, *hifdh al nafs*; preservation of progeny, *hifdh al nasl*; preservation of intellect, *hifdh al 'aql*; and preservation of wealth, *hifdh al maal*. Any medical action must fulfill one of the above purposes if it is to be considered ethical. If any medical procedure violates any of the 5 purposes it is deemed unethical.”

<sup>iv</sup> These types of bioethical issues are increasingly gaining attention around the Muslim world. *The First International Bioethics Conference* in Muscat Oman in 2015 exemplifies just how robust discussions around Islam, bioethics, and healthcare are. For instance, the three-day conference, which was attended by scholars from around the world, dealt with a variety of issues ranging from the theoretical (such as Formulating a Juristic Theory on Islamic Jurisprudence and Global Social Responsibility) to the more practical (for instance, Womb Transplants and Children and Autonomy). Details for the conference, together with a full agenda can be found at: <http://conference.squ.edu.om/Default.aspx?tabid=1682>.

<sup>v</sup> Furthermore, many point to the edict stating that “all actions are in principle permissible as they are not categorically prohibited” and furthermore, “In matters in which other invocations are silent then the concept of maslaha (public interest) applies” (IMANA, 2016).

<sup>vi</sup> This opinion was shared by attendees at the First International Conference in Bioethics in the Muslim World, Cairo (1991), as well as representatives from; the Fiqh Council of North America, the International Institute of Islamic Thought, The Islamic Organization of Medical Sciences, the Society of Islamic Medical Sciences of the Syndicate of Jordanian Physicians Conference, and the Muslim World League's Islamic Fiqh Council.

<sup>vii</sup> For the purpose of this study we have chosen to define end of life as it relates to Do Not Resuscitate orders (DNR), euthanasia and dysphasia (where euthanasia refers to the use of medication or other methods to purposely accelerate the passing of a terminally ill patient, while dysphasia refers to withholding or withdrawing of treatment from a terminally ill patient).

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<sup>viii</sup> Our research indicates that the majority opinion feels that the act of playing God refers more to the processes of euthanasia, and not towards DNR itself, which is seen more as an act of necessary mercy.