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The Moral Universe of Muslim Healthcare Practitioners in the UK: Balancing Islamic and Secular Ethics in Palliative and End of Life Care

Abstract

In this paper, we evaluate the ethical challenges faced by Muslim healthcare professionals (HCPs) working in palliative and end of life care (P&EOLC) in the UK. Aiming to contribute to an empirical foundation upon which ethical support systems for religious HCPs can be built, we compare Islamic moral frameworks with the secular ethics of the NHS and assess how Muslim HCPs navigate the integration of both.

This qualitative study includes 76 semi-structured interviews with Muslim patients, family members, and a variety of Muslim and non-Muslim palliative care providers. Important themes were the central role of Islam, Islamic beliefs and values surrounding P&EOLC, and difficulties in navigating multiple moral frameworks resulting in significant moral distress among Muslim HCPs.

Our study reveals a pressing need for better ethical support systems for religious HCPs and more inclusive workplaces in healthcare. We suggest developing ethical guidance incorporating religious perspectives, offering cultural and religious competence training to staff, and establishing peer support groups to aid Muslim HCPs in aligning their professional duties with their faith, preserving their integrity and well-being. We recommend future research focuses on gathering more empirical data from diverse Muslim populations, developing effective ethical support mechanisms, and studying their impact.

Introduction

Our objective with this paper is to enhance the understanding of the moral universe of Muslim healthcare professionals (HCPs) working in palliative and end of life care (P&EOLC) in the UK. HCPs encounter ethically challenging situations more frequently than people in most other professions. Their moral frameworks guide their ethical decision-making processes. Examining

these frameworks can therefore elucidate how HCPs address moral challenges, which might offer clarity for resolving conflicts.

Studying the moral universe of Muslim HCPs in the UK specifically is becoming increasingly important. The UK is more culturally, religiously, and ethnically diverse today than ever before. In 2021, approximately 6.5% of the population was Muslim compared to 4.8% in 2011, making Islam the fastest growing religion in the UK [1] [2]. These demographic developments are evident in the healthcare workforce too; in 2020 3.3% of the 1.4 million NHS workers identified as Muslim [3].

Regrettably, as is the case for most minority groups, this population remains understudied. This lack of academic interest is worrisome: ethnicity, culture, and religion influence perceptions on life and death, sickness and health, and inform personal values, beliefs, and moral frameworks [4] [5]. Consequently, Muslim HCPs in the UK risk facing complex ethical dilemmas when their religious moral framework is at odds with the expectations of the secular healthcare system [6] [7].

Existing literature corroborates the occurrence of such ethical dilemmas. Elzamzamy and Keshavarzi discuss the obstacles Muslim HCPs ran into when their religious beliefs clashed with their patient's values concerning topics such as abortion, sexual orientation, and substance use [8]. Tomkins et al. explored how religious views on the sanctity of life engender explicit beliefs surrounding the appropriate use of healthcare technologies. In the context of P&EOLC, they accentuate how many religion-base groups oppose the secular advocacy for assisted suicide and euthanasia [9].

Literature on Islamic beliefs and values surrounding P&EOLC exists, however, these texts are often based on Islamic teachings and texts, rather than empirical data and the lived experiences of Muslim HCPs. Filling this gap is crucial: Muslim HCPs in secular systems like the NHS are at risk of moral distress and moral injury. This risk ensues from the inability to align their religious beliefs with their professional obligations, therefore having to compromise either one at risk of their professional or personal integrity. Such breaches of integrity undermine mental well-being and, in some cases, contribute to burnout [10] [11]. Gaining a better insight in the Muslim moral universe could help facilitate culturally competent working environments and mitigate these negative effects.

Besides benefiting Muslim HCPs, culturally competent working environments that promote diversity and inclusion appear to offer other advantages. Smedley and Mittman describe how a diverse workforce results in better access to care for minority groups, enhanced patient satisfaction and trust, and improved health outcomes [12]. It seems indisputable that culturally competent working environments for our increasingly diverse workforce are a worthwhile investment.

This empirical paper is the first part of a three-part series seeking to better understand the moral universe of Muslim HCPs in the UK. Our purpose is to contribute to the empirical and normative foundation of knowledge needed for ethical support systems designed to help religious HCPs handle ethical dilemmas without compromising their integrity. Hopefully, this

contributes to establishing culturally competent and inclusive working environments, which promote the well-being of a diverse workforce and, consequently, improve patient care. For this paper, we have combined a theoretical background with an analysis of our own data to address the following research objectives:

1) Determine the role of Islamic texts and practices in the moral framework of Muslim HCPs.
2) Identify key virtues and ethical principles from Islamic theology and explore how they inform professional conduct.
3) Analyse challenges faced by Muslim HCPs when navigating multiple moral frameworks simultaneously.

Theoretical background

This section provides a brief theoretical background on secular and Islamic beliefs and values concerning death, dying, and P&EOLC to better understand the nature of the ethical dilemmas Muslim HCPs run into.

Secular Medical Ethics

The Hippocratic Oath, dating back to the 5th century BCE, is often considered one of the oldest influences on secular medical ethics. It established the principles of non-maleficence, beneficence, and confidentiality, which laid the groundwork for the codes of conduct we adhere to today [13] [14].

In subsequent centuries, Christianity spread through the Western world. The Christian Church adopted the Hippocratic tradition and infused it with Christian moral teachings. Medieval theologians like Thomas Aquinas preached that caring for the sick was both a moral responsibility and a religious duty [15]. These ideologies, along with Christian principles of charity and the sanctity of life, motivated monastic orders to found hospitals where they cared for the sick and dying [16].

During the Enlightenment, philosophers advocated for a shift away from theological constraints. New, radical ideas of a secular nature took hold, focusing on man's innate intellectual and moral development as a vital part of natural progression [17]. Reason, individual autonomy and empirical science became greatly valued, contributing to the birth of modern medical ethics.

In the 20th century, the atrocities of the second World War led to the establishment of the Nuremberg Code and the Declaration of Helsinki, putting patient rights and informed consent front and centre [18] [19]. In the 70s, Beauchamp and Childress published their famous four principles approach which is used to guide clinical decision-making to this day [20].

In the context of P&EOLC, secular ethics prioritises patient autonomy and the right to self-determination above many other values. This is reflected in practices, such as advance directives, do-not-resuscitate (DNR) orders, and the legalisation of euthanasia and assisted suicide in some countries.

Islamic Medical Ethics

Islamic ethics dates from the 7th century and is rooted in Islam's primary sources, the Quran and Hadith, and secondary sources, the works of Islamic scholars. These texts offer a moral framework embracing all aspects of Muslim life and provide clear moral instructions for believers [21]. The sources discuss concepts of health, sickness, life, and death. Islamic ethics recognises the inevitability of death, but considers the sanctity of life and its preservation paramount. While this principle underpins much of Islamic medical ethical thinking, abiding by it is not absolute [22] [23].

An equally pivotal concept is *taqwah,* the psychological state of being conscious of God at all times. *Taqwah* is accompanied by the virtues of *sabr* (patience) and *shukr* (gratefulness). Achieving *taqwah* requires steadfastness in faith, especially during times of hardship, and acceptance of God's plan. Equally rooted in *taqwah,* stemming from confidence and faith in God's power, is hope for *shifa*, God's cure and miracles, until the moment of death [24].

Muslim beliefs and practices around death and dying demonstrate a profound dedication to a metaphysical reality that exists beyond empirical knowledge [25]. In P&EOLC, Islamic ethics emphasises the sanctity of life, the existence of an afterlife, and the inevitability of *qadar*, or divine will. The belief in an authority higher than man results in less value being assigned to patient autonomy.

Muslim Healthcare Professionals in Secular Contexts

The previous paragraphs highlight the key differences between Islamic and secular ethics in the context of P&EOLC. The secular focus on empirical evidence and scientific methodology may not always align with Islamic theological and metaphysical values. Inevitably, Muslim HCPs in a secular healthcare system are susceptible to significant challenges when navigating these two belief systems concurrently.

One area of conflict concerns what is a 'good' death. In secular P&EOLC, the goal is often to minimise physical suffering and facilitate a 'comfortable' death. In contrast, Muslims may consider suffering to be of spiritual significance, and consequently focus more on ensuring that death occurs in a state of religious preparedness [26]. Sources of moral distress for Muslim HCPs in this context may concern the appropriateness of medical practices, such as withdrawal of life support or euthanasia.

Whereas secular ethics prioritises patient autonomy and informed consent, Islamic ethics may emphasise communal decision-making. Also important in Islamic ethics is balancing acceptance of a terminal diagnosis with a commitment to steadfast belief in God's power and hopes for a cure. Muslim HCPs are frequently left in impossible predicaments, having to choose between adhering to their faith and meeting professional guidelines.

Methodology

This paper draws on a secondary analysis of a large qualitative dataset that has previously been reported [5]. Accordingly, we have included a concise overview of the methodology in Appendix A. That study examined palliative and end-of-life care (P&EOLC) experiences among Muslim

patients, family carers, and healthcare providers in England. For the purposes of the present analysis, we undertook a focused re-examination of all interview transcripts involving Muslim HCPs with the aim of understanding how they navigate potentially competing Islamic and secular ethical frameworks in clinical decision-making.

Dataset and Sampling

The full dataset comprises 76 semi-structured interviews conducted between 2018 and 2020. From this dataset, we identified all interviews involving:

1. Participants who self-identified as Muslim, and
2. Held a professional role within healthcare (chaplain, imam, nurse, doctor, or allied health professional).

Using this definition, 17 participants were included in this analysis:

- Doctors (n = 13)
- Nurses (n = 2)
- Allied Health Professionals (n = 2)

Participants worked across a range of specialties, including:

- General Practice (five clinicians)
- Palliative Care (two consultants; one additional clinician; one student nurse)
- General Medicine, Cardiology, ITU, Neonatal ITU
- AHP roles (physiotherapy/OT-equivalent roles)

This ensures that the analysis reflects the perspectives of clinicians who deliver direct patient care and make or enact decisions relating to end-of-life treatment.

Data Collection

Interviews were conducted in person or online using a semi-structured topic guide examining experiences of P&EOLC, perceptions of good care, the role of religion, and ethical dilemmas encountered in practice. All interviews were audio-recorded, transcribed verbatim, and conducted with informed consent.

Analytic Approach

We applied a targeted qualitative content analysis focused on:

- Religious and moral reasoning,
- Tensions between Islamic values and secular clinical norms,
- Experiences of moral distress, and
- Strategies for navigating competing expectations.

Although this analysis draws on a dataset reported previously, this paper provides a distinct contribution, namely:

1. A dedicated analysis of Muslim clinicians in P&EOLC contexts
2. An expanded conceptual examination of Islamic moral reasoning alongside secular bioethics.

3. A normative discussion exploring institutional responsibilities to support religiously diverse clinicians.

Results

Of the 76 interviews in the broader dataset, 17 involved Muslim healthcare professionals (doctors, nurses, or allied health professionals) and form the basis of this analysis. These clinicians represented a wide range of specialties, including general practice, palliative care, cardiology, general medicine, intensive care, neonatal intensive care, and allied health. Four participants were directly involved in specialist or generalist palliative and end-of-life care; others encountered end-of-life decisions in acute or primary care settings. The diversity of roles provided insights into both specialist and non-specialist encounters with ethical tension in P&EOLC. The analysis highlights three central themes (1) the role of Islam in shaping their professional identities (2) the Islamic values and beliefs relevant to P&EOLC, and (3) their lived experiences of navigating two potentially conflicting value systems. Appendix B provides illustrative interview excerpts supporting the themes discussed below.

Central Role of Islam

The interviews reveal that Islam has a deep impact on the personal and professional lives of Muslim HCPs. Participants stress the inseparability of their faith and their professional practice, despite working in a secular environment. Islam shapes their moral frameworks and colours their ethical deliberations regarding death and dying. Consequently, Islam affects their perceptions on good P&EOLC.

Some participants describe how their training in a secular system required them to separate their faith from their professional lives. This accentuates the tension between their professional training and personal beliefs which leads to guilt and internal conflict among Muslim HCPs. It highlights the need for medical training to integrate and respect diverse ethical perspectives, fostering an environment where practitioners can reconcile their faith with their practice.

Islamic values, beliefs, and perspectives on good P&EOLC

The participants provided abundant information on the Islamic beliefs and values that shape their views on death and dying. The sanctity of life, meaning that life is sacred and should be preserved, is considered paramount. This belief conflicts with the secular emphasis on patient autonomy and quality of life, from which flows the right to refuse or cease life-sustaining treatments. Participants expressed discomfort with decisions that might shorten a patient's life. However, this commitment is nuanced, as the dedication to preserving life does not equate to a denial of imminent death [27]. The belief in the afterlife provides a broader spiritual context for P&EOLC. This belief encourages a focus on spiritual readiness as a patient approaches death. In this context, good P&EOLC includes providing opportunities for prayer, recitation of the Quran, and other religious practices.

Rather than individual patient autonomy, Islamic teachings emphasise communal decision-making and the importance of involving family members [28]. Furthermore, Muslim HCPs may struggle to balance providing honest and full information about a terminal diagnosis, whilst

respecting a patient's ability to hope [29]. Participants noted specifically that faith can give people hope, context, and ease.

Adab (proper conduct) and *aqhlaq* (virtue) are essential concepts in Islam. They are the foundation of Muslim identity and provide a framework for good behaviour. They also guide interactions in clinical settings and define good end of life care. *Adab* focuses on external behaviour and the interactions with others; it relates to good manners and respect. In healthcare, this would translate to treating patients with respect and dignity. Kindness and compassion in interaction with patients is considered very important by the participants. *Aqhlaq* extends beyond mere actions to the motivation behind those actions and one's inner qualities. It involves moral character and the embodiment of Islamic ethical principles. For HCPs, this often means balancing medical decisions with their moral integrity.

Negotiating Competing Moral Frameworks and Reconciling Professional and Personal Ethical Commitments

Muslim HCPs in the UK often find themselves at crossroads between their religious values and the secular professional codes of conduct. A recurrent theme was the tension between the Islamic emphasis on preserving life and the secular emphasis on patient autonomy and quality of life. Participants were found to feel particularly uncomfortable with decisions that prioritise patient autonomy and quality of life over the sanctity of life. One participant remembers feeling '*absolutely dreadful'* when asked to cease the administration of foods and fluids to expedite the last phase of life. Additionally, participants expressed difficulty in balancing the commitment to preserving life with the acceptance of imminent death. Their belief in the sanctity of life and the afterlife resulted in HCPs feeling distressed when having to perform certain tasks, such as signing DNR-orders or cremation forms.

Despite these challenges, Muslim HCPs show incredible resilience and employ various strategies to reconcile their professional duties with their religious beliefs. Some rely on networks of colleagues and friends who share similar values [30]. Others seek guidance from religious scholars and community leaders. One participant described how they attempt to separate their personal perspectives from the clinical work by deferring the actual decision-making to the patient as often as possible. Other participants express how their faith is also a source of strength in difficult moments.

Lack of Support Mechanisms

The inadequacies of the current healthcare system in supporting Muslim HCPs were of specific concern to the participants. They discuss the absence of culturally sensitive training opportunities and guidance to address their ethical dilemmas. Participants felt that they are met with very little flexibility when their personal beliefs conflict with their professional duties. This lack of support and sensitivity leaves Muslim HCPs feeling distressed.

Participants called for better training programs including modules on cultural competence and the specific needs of religious HCPs. Organisations like the Initiative on Islam and Medicine (II&M) in the United States partly fill this gap by offering (amongst other services) courses on Islamic bioethics and contemporary medicine [31]. Unfortunately, such courses are not universally available, must be paid for by the HCPs themselves, and taken in their free time.

Moreover, these courses are generally not attended by non-Muslim HCPs, which limits their effectiveness in improving cultural competence in the workplace.

Discussion

This study provides an in-depth examination of how Muslim clinicians, doctors, nurses, and allied health professionals, navigate the intersection of Islamic moral reasoning and the secular ethical frameworks governing palliative and end-of-life care (P&EOLC) in the UK. This analysis extends earlier work based on the same dataset [5] by focusing exclusively on clinicians and their professional moral worlds, which were only partially represented in the original publication.

Our findings show that Islamic beliefs and values, including the sanctity of life, the importance of divine decree (*qadar*), and the virtues of *sabr, shukr*, and *taqwa*, deeply shape the ethical reasoning of Muslim clinicians. Participants described how these values inform their judgments about maintaining hope, disclosing prognostic information, assessing the moral acceptability of withdrawing life-sustaining treatment, and involving families in decision-making. In this regard, our findings align with scholarship documenting the centrality of theological concepts in shaping Muslim attitudes to illness, suffering, and death [21] [22] [32-37].

Relationship to Existing Literature

Findings in Muslim-majority healthcare systems

Internationally, clinicians in Muslim-majority settings report similar ethical tensions, particularly around decisions perceived to hasten death. Studies from Muslim majority contexts describe clinicians' reluctance to withdraw life support and the ethical emphasis placed on divine hope for healing [38-41]. The parallels suggest that the tensions observed in this study are not solely artefacts of working within a secular system but reflect deeper moral commitments embedded in Islamic epistemology and jurisprudence.

At the same time, the contextual pressures in the UK differ markedly. UK law and NHS guidance emphasise autonomy, self-determination, advance directives, and the permissibility of withdrawing clinically assisted nutrition and hydration. Several clinicians in our study described moral distress when institutional expectations encouraged decisions that felt misaligned with principles of life preservation or relational decision-making.

Comparisons with clinicians from other faith traditions

Our findings also align with a well-established body of work showing that religious clinicians of many traditions experience ethical tensions when institutional norms diverge from their moral frameworks. Catholic clinicians frequently describe conflicts in reproductive ethics [42]; Orthodox Jewish clinicians express concerns around *halachic* prohibitions relating to life-ending decisions [43]; Christian clinicians have reported similar distress in jurisdictions permitting physician-assisted dying. These cross-faith parallels strengthen the argument that the core

challenge lies not in Islam per se, but in the limited accommodation of moral pluralism within dominant secular bioethical models.

Moral Distress and Moral Negotiation

A significant and recurring theme was moral distress, experienced when clinicians were required to participate in decisions or actions perceived to conflict with their religious moral commitments. This aligns with empirical literature demonstrating that religious or minoritised clinicians experience disproportionate levels of moral distress [44] Muslim clinicians in this study described feeling "torn", "troubled", or "complicit" when their professional duties involved withdrawing treatment, signing DNR orders, or presenting prognoses in ways that felt incompatible with Islamic virtues of maintaining hope and minimising spiritual harm. Clinicians used a range of negotiation strategies, including: seeking guidance from religious scholars or trusted colleagues, reframing their role as facilitating patient autonomy rather than endorsing decisions, compartmentalising personal belief and professional practice, delegating particular procedural tasks to colleagues.

These strategies reflect what workplace religion theorists describe as "moral boundary-work"[45], the ongoing, dynamic effort required to sustain moral integrity in environments structured around different normative assumptions.

Learning from International and Interfaith Practice

In Muslim-majority settings, conflicts between religious ethics and clinical practice are often mediated by institutional religious scholars, integrated ethics committees, or shared family decision-making models [46][47]. These examples illustrate that value pluralism is not inherently destabilising; rather, institutional mechanisms can mitigate conflict.

Promising Practices and Support Mechanisms

In terms of actionable recommendations, our analysis highlights the value of:

1. Faith-sensitive clinical ethics consultation

Clinical ethics services that explicitly incorporate religious reasoning, rather than presuming secular neutrality, may help clinicians articulate concerns and explore ethically legitimate alternatives

2. Reflective forums with moral and spiritual dimensions

Schwartz Rounds or structured debriefings can be adapted to include moral and theological dimensions, acknowledging that distress often arises from value conflict rather than emotional burden alone.

3. Peer and mentorship networks

Models such as MuslimMeds (Canada) and BIMA (UK) provide safe, confidential spaces for moral reflection among religious clinicians and can reduce professional isolation.

4. Community-engaged P&EOLC models

Heirali et al.'s [48] work on Muslim advance care planning demonstrates how community consultation and engagement with religious leaders can improve alignment between care preferences and clinical decision-making.

5. Conscientious reflection pathways

Rather than relying solely on formal conscientious objection, which is often binary and adversarial, institutions can develop structured pathways that allow clinicians to voice concerns and seek adaptations where feasible.

Together, these examples point toward organisational strategies that enable clinicians to maintain moral integrity while fulfilling professional responsibilities.

Strengths and Limitations

A key strength of this study is its exclusive focus on 17 Muslim clinicians, a group whose moral reasoning directly shapes patient care decisions. The inclusion of both specialist and non-specialist P&EOLC clinicians expands current understandings of how moral tensions emerge in varied clinical environments.

Limitations include the modest sample size and reliance on secondary analysis of data not originally designed to explore institutional dimensions of moral distress. While the sample reflects diverse ethnic and theological backgrounds, it does not capture the full spectrum of Islamic jurisprudential perspectives. Finally, chaplains and imams were intentionally excluded from this analysis to preserve conceptual clarity around clinical decision-making, though their perspectives are valuable and merit future research.

Conclusion

This study offers a detailed, empirically grounded account of how Muslim clinicians negotiate the moral tensions between Islamic and secular ethical frameworks in P&EOLC. Their experiences highlight the limits of a purely autonomy-driven, secular model of ethics in supporting a religiously diverse workforce. Institutional recognition of moral pluralism, through faith-sensitive ethics support, reflective spaces, and community-engaged models, may help protect the wellbeing and integrity of clinicians while improving the quality and inclusivity of care.

Bibliography

1. Office for National Statistics (ONS), released 30 January 2023, ONS website, article, Religion by age and sex, England and Wales: Census 2021

2. Muslim Council of Britain. (2022, 2 december). 2021 Census: As UK Population Grows, So Do British Muslim Communities | Muslim Council of Britain. Muslim Council Of Britain. https://mcb.org.uk/2021-census-as-uk-population-grows-so-do-british-muslim-communities/

3. England, N. (2020, 21 mei). NHS England » NHS thanks Muslim staff working through Ramadan and urges care over Eid. https://www.england.nhs.uk/2020/05/nhs-thanks-muslim-staff-working-through-ramadan-and-urges-care-over-eid/

4. Pentaris, P., & Tripathi, K. (2022). Palliative Professionals' Views on the Importance of Religion, Belief, and Spiritual Identities toward the End of Life. International journal of environmental research and public health, 19(10), 6031. https://doi.org/10.3390/ijerph19106031

5. Suleman, M. (2022). The balancing of virtues—Muslim perspectives on palliative and end of life care: Empirical research analysing the perspectives of service users and providers. Bioethics, 37(1), 57–68. https://doi.org/10.1111/bioe.13109

6. Suleman, M. (2022). The balancing of virtues—Muslim perspectives on palliative and end of life care: Empirical research analysing the perspectives of service users and providers. Bioethics, 37(1), 57–68. https://doi.org/10.1111/bioe.13109

7. Elzamzamy, K., & Keshavarzi, H. (2019). Navigating Ethical Dilemmas in Mental Health Practice Between Professional Ethics and Islamic Values. Journal Of Islamic Fatih And Practice, 2(1), 40–71. https://doi.org/10.18060/23274

8. Elzamzamy, K., & Keshavarzi, H. (2019). Navigating Ethical Dilemmas in Mental Health Practice Between Professional Ethics and Islamic Values. Journal Of Islamic Fatih And Practice, 2(1), 40–71. https://doi.org/10.18060/23274

9. Tomkins, A., Duff, J., Fitzgibbon, A., Karam, A., Mills, E. J., Munnings, K., Smith, S., Seshadri, S. R., Steinberg, A., Vitillo, R., & Yugi, P. (2015). Controversies in faith and health care. Lancet, 386(10005), 1776–1785. https://doi.org/10.1016/s0140-6736(15)60252-5

10. Lamiani, G., Borghi, L., & Argentero, P. (2016). When healthcare professionals cannot do the right thing: A systematic review of moral distress and its correlates. Journal Of Health Psychology, 22(1), 51–67. https://doi.org/10.1177/1359105315595120

11. British Medical Association. (z.d.). Recognising and tackling moral distress and moral injury in UK doctors. In British Medical Association Recognising And Tackling Moral Distress And Moral Injury in UK Doctors. https://www.bma.org.uk/media/4216/bma-moral-distress-paper.pdf P6

12. Smedley, B.D., Mittman, I.S. (2011). The Diversity Benefit: How Does Diversity Among Health Professionals Address Public Needs?. In: Williams, R. (eds) Healthcare Disparities at the Crossroads with Healthcare Reform. Springer, Boston, MA. https://doi.org/10.1007/978-1-4419-7136-4_11

13. LibGuides: Bioethics: Hippocratic Oath. https://dal.ca.libguides.com/c.php?g=256990&p=1717826

14. Smith, D. C. (1996). The Hippocratic Oath and Modern Medicine. Journal Of The History Of Medicine And Allied Sciences, 51(4), 484–500. https://doi.org/10.1093/jhmas/51.4.484 p.500

15. Summa Theologiae, second part of the second part, amongst others question 31 (https://www.newadvent.org/summa/3031.htm)

16. Knowles, R. & Christian Medical Fellowship. (z.d.). The Christian contribution to healthcare. Christian Medical Fellowship - cmf.org.uk. https://www.cmf.org.uk/resources/publications/content/?context=article&id=26520

17. Medicine in Society Historical Essays , pp. 149 – 196 DOI: https://doi.org/10.1017/CBO9780511599682.006

18. UNC Research. (2024, 6 mei). Nuremberg Code - UNC Research. https://research.unc.edu/human-research-ethics/resources/ccm3_019064/

19. WMA - The World Medical Association-WMA Declaration of Helsinki – Ethical Principles for Medical Research Involving Human Subjects. (z.d.). WMA - The World Medical Association-WMA Declaration Of Helsinki – Ethical Principles For Medical Research Involving Human Subjects. https://www.wma.net/policies-post/wma-declaration-of-helsinki-ethical-principles-for-medical-research-involving-human-subjects/

20. Beauchamp, T. L., & Childress, J. F. (2001). Principles of Biomedical Ethics. Oxford University Press, USA.

21. Ilkilic, I. (2008). The Discourses of Islamic Medical Ethics. In Cambridge University Press eBooks (pp. 270–278). https://doi.org/10.1017/chol9780521888790.019 p.270

22. Gatrad, A. R. (2001). Medical ethics and Islam: principles and practice. Archives Of Disease in Childhood, 84(1), 72–75. https://doi.org/10.1136/adc.84.1.72

23. Kristiansen, M., & Sheikh, A. (2012). Understanding faith considerations when caring for bereaved Muslims. Journal Of The Royal Society Of Medicine, 105(12), 513–517. https://doi.org/10.1258/jrsm.2012.120284

24. Suleman, M. (2022). The balancing of virtues—Muslim perspectives on palliative and end of life care: Empirical research analysing the perspectives of service users and providers. Bioethics, 37(1), 57–68. https://doi.org/10.1111/bioe.13109

25. Suleman, M. (2022). Muslim Values and End-of-Life Healthcare Decision-Making: Values, Norms and Ontologies in Conflict?. In: al-Akiti, A., Padela, A.I. (eds) Islam and Biomedicine. Philosophy and Medicine, vol 137. Springer, Cham. https://doi.org/10.1007/978-3-030-53801-9_8

26. Kristiansen, M., & Sheikh, A. (2012). Understanding faith considerations when caring for bereaved Muslims. Journal Of The Royal Society Of Medicine, 105(12), 513–517. https://doi.org/10.1258/jrsm.2012.120284

27. Suleman, M. (2022). The balancing of virtues—Muslim perspectives on palliative and end of life care: Empirical research analysing the perspectives of service users and providers. Bioethics, 37(1), 57–68. https://doi.org/10.1111/bioe.13109

28. Suleman, M. (2022). The balancing of virtues—Muslim perspectives on palliative and end of life care: Empirical research analysing the perspectives of service users and providers. Bioethics, 37(1), 57–68. https://doi.org/10.1111/bioe.13109

29. Sachedina, A. (2006). The search for Islamic bioethics principles. Principles of health care ethics, 117-125.

30. Suleman, M. (2022). The balancing of virtues—Muslim perspectives on palliative and end of life care: Empirical research analysing the perspectives of service users and providers. Bioethics, 37(1), 57–68. https://doi.org/10.1111/bioe.13109

31. Get support | British Islamic Medical Association. (z.d.). British Islamic Medical Association. https://britishima.org/get-support/

32. About II&M. Initiative On Islam And Medicine. https://www.medicineandislam.org/overview/

33. Pawlikowski, J., Sak, J. J., & Marczewski, K. (2012). Physicians' religiosity and attitudes towards patients. Annals of Agricultural and Environmental Medicine, 19(3).

34. Suleman, M. (2022). The balancing of virtues—Muslim perspectives on palliative and end of life care: Empirical research analysing the perspectives of service users and providers. Bioethics, 37(1), 57–68. https://doi.org/10.1111/bioe.13109

35. Héliot, Y., Gleibs, I. H., Coyle, A., Rousseau, D. M., & Rojon, C. (2019). Religious identity in the workplace: A systematic review, research agenda, and practical implications. Human Resource Management, 59(2), 153–173. https://doi.org/10.1002/hrm.21983

36. Sachedina, A. (2006). The search for Islamic bioethics principles. Principles of health care ethics, 117-125.

37. https://www.bma.org.uk/media/4216/bma-moral-distress-paper.pdf (P6 provides numbers on moral distress amongst doctors from a minority background compared to white doctors)

38. Aghabarary, M., & Nayeri, N. D. (2017). Reasons behind providing futile medical treatments in Iran: A qualitative study. *Nursing ethics*, *24*(1), 33-45.

39. Asadi, N., Royani, Z., Maazallahi, M., & Salmani, F. (2021). Being torn by inevitable moral dilemma: experiences of ICU nurses. *BMC medical ethics*, *22*(1), 159.

40. Mohamad, M. I. B. K., Hamdan, M. N., & Yusof, A. N. M. (2025). Third-party refusal of medical treatment–a critical analysis of case report from Islamic ethical perspectives. *BMC Medical Ethics*, *26*(1), 48.

41. Abdullah, R., Guo, P., & Harding, R. (2020). Preferences and experiences of Muslim patients and their families in Muslim-majority countries for end-of-life care: a systematic review and thematic analysis. *Journal of pain and symptom management*, *60*(6), 1223-1238.
42. Curlin, F. A., Lawrence, R. E., Chin, M. H., & Lantos, J. D. (2007). Religion, conscience, and controversial clinical practices. *New England Journal of Medicine*, *356*(6), 593-600.
43. Loike, J., Gillick, M., Mayer, S., Prager, K., Simon, J. R., Steinberg, A., ... & Fischbach, R. L. (2010). The critical role of religion: Caring for the dying patient from an Orthodox Jewish perspective. *Journal of Palliative Medicine*, *13*(10), 1267-1271.
44. Lamiani, G., Borghi, L., & Argentero, P. (2017). When healthcare professionals cannot do the right thing: A systematic review of moral distress and its correlates. *Journal of health psychology*, *22*(1), 51-67.
45. Héliot, Y., Gleibs, I. H., Coyle, A., Rousseau, D. M., & Rojon, C. (2020). Religious identity in the workplace: A systematic review, research agenda, and practical implications. *Human resource management*, *59*(2), 153-173.
46. Mansoor, F. (2024). Healthcare Decisions in Islam: Key Ethical Considerations. *Journal of World Religions and Interfaith Harmony*, *3*(2), 138-148.
47. Elamin, M. O. I. (2024). Religious Approaches to Bioethical Reasoning: Bridging Values and Ethics. *International Journal of Religion*, *5*(12), 886-898.
48. Heirali, A. A., Javed, S., Damani, Z., Kachra, R., Valiani, S., Walli, A. K., ... & Karim, S. (2021). Muslim perspectives on advance care planning: a model for community engagement. *Palliative Care and Social Practice*, *15*, 2632352421997152.