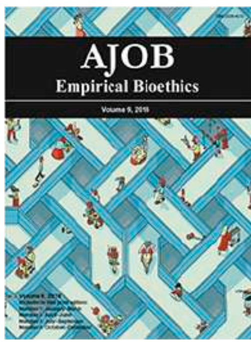

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“God is the giver and taker of life”: Muslim beliefs and attitudes regarding assisted suicide and euthanasia

Chaïma Ahaddour, Stef Van den Branden, and Bert Broeckaert

Faculty of Theology and Religious Studies, KU Leuven (Research Unit of Theological and Comparative Ethics), Leuven, Belgium

ABSTRACT
In the context of the Belgian debates on end-of-life care, the views of Muslims remain understudied. The aim of this article is twofold. First, we seek to document the relation between contemporary normative Muslim ideas on assisted suicide and voluntary euthanasia on the one hand and real-world views and attitudes of Muslims living in Belgium on the other hand. Second, we aim to identify whether a shift is observable in the views and attitudes regarding active termination of life between first- and second-generation Muslims. We have observed that when dealing with these bioethical issues, both first- and second-generation Muslims adopt a theological line of reasoning similar to the one that can be found in normative Islamic views. We have found an absolute rejection of every act that deliberately terminates life, based upon the unconditional belief in an afterlife and in God’s sovereign power over life and death.

KEYWORDS
assisted suicide; euthanasia; Islam; Belgium; Europe; Moroccan Muslim women; qualitative empirical research

A number of Western countries have actively debated euthanasia over the last 30 years. The debate has centered on a right to die based on the principles of autonomy, individuality, and the right to self-determination (Cohen et al. 2006a; 2006b). More recently, a number of publications have included discussions of contemporary bioethical issues including euthanasia from a normative Islamic point of view (Al-Bar and Chamsi-Pasha 2015; Arda and Rispler-Chaim 2012; Atighetchi 2007; Brockopp 2004; Brockopp and Eich 2008; Ghaly 2016; Rispler-Chaim 1993; Sachedina 2005, 2009; Shanawani and Khalil 2008), and a large number of legal opinions (*fatāwā*/*fatwas*) have been issued by Islamic scholars through different media (cf. Islamic Organization of Medical Sciences, Islamic *Fiqh* Academy, International Islamic *Fiqh* Academy, European Council for Fatwa and Research) (Al-Bar and Chamsi-Pasha 2015; Van den Branden and Broeckaert 2009; 2010a; 2010b). However, the number of empirical studies that deal with the views of the rapidly growing number of Muslims living in the West on specific ethical dilemmas at the end of life is very limited (Ahaddour, Van den Branden, and Broeckaert 2017; Baeke 2012; Van den Branden 2006). Given the fact that Europe and, more specifically, Belgium are becoming more multicultural and multireligious, care can no longer be provided solely from a Christian or Western secular framework. Additionally, it is of great importance to provide adequate and dignified end-of-life care.

In this article we ask what the relationship is between normative Islamic views on assisted suicide and voluntary euthanasia on the one hand and real-world views and attitudes of Muslims living in a Western, European society on the other hand. Is there a wide gap between normative Islamic viewpoints and what ordinary Muslims believe and think? And can we observe a shift in views and attitudes when we compare first- and second-generation Muslims in Belgium, given that in Belgium this second generation shows much more socioeconomic diversity and has presumably been more strongly influenced by the Western society its members live in and have been brought up in?

Normative islamic views on assisted suicide and euthanasia

Islam has no central religious authority. Muslim scholars deploy a variety of approaches to ethics, often resulting in a variety of opinions (*fatāwā*/*fatwas*) within Islamic jurisprudence (*fiqh*) (Al-Bar and Chamsi-Pasha 2015; Arda and Rispler-Chaim 2012; Atighetchi 2007; Rispler-Chaim 1993; Sachedina 2012). However, regarding the active termination of life a univocal negative answer is found within normative Islamic and international scholarly literature (see *fatwas* issued by Islamic Organization of Medical Sciences, Islamic *Fiqh* Academy, International Islamic *Fiqh* Academy, European Council for Fatwa and Research) (Al-Bar and Chamsi-Pasha 2015; Van den Branden and Broeckaert 2009; 2010a; 2010b). Any active form of life termination is radically rejected and prohibited on the basis of a number of theological arguments and convictions. First, Islam does not recognize the right to die voluntarily. Deliberately ending one’s life is considered suicide and is equated with murder when there is a physician involved. Both murder and suicide are perceived as grave sins (Al-Shahri 2016; Atighetchi 2007; Ayuba 2016; Brockopp 2008; Choong 2015; Rahman 1998; Rispler-Chaim 1993; Sarhill et al. 2001; Van den Branden and Broeckaert 2010b). Yousuf and Fauzi (2012) and Al-Bar and Chamsi-Pasha (2015) explain that from

CONTACT Chaïma Ahaddour chaima.ahaddour@kuleuven.be Faculty of Theology and Religious Studies, KU Leuven (Research Unit of Theological and Comparative Ethics), Leuven, Belgium. Sint-Michielsstraat 6, Box 3101, Leuven, 3000, Belgium.
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a Quranic point of view, saving a person's life is equated with saving the lives of the whole of mankind, and taking someone's life unjustly is tantamount to the killing of mankind in its entirety. Rahman (1998) and Al-Jahdali et al. (2013) explicitly state that in Islam the concept of a life not worth living is unacceptable. On the other hand, Padela and Qureshi (2016, 11) state that "one could argue that judgements about when a certain type of life need not be brought into this world and when a certain type of life can be allowed to expire are two sides of the same coin as they attend to a moral vision for what constitutes a life worth living (or a life worth preserving medically)." Indeed, withdrawal of life support when patients are not expected to recover, are terminally ill, or are declared brain dead is permitted by some Islamic scholars and judicial bodies (Ebrahim 2001; Padela and Qureshi 2016; Sachedina 2009). In the context of abortion, different perspectives exist within the Islamic legal schools and among the Islamic scholars (e.g., based on the idea of ensoulment) about when and in which (strict) circumstances an abortion can be initiated (Athar 2016; Atighetchi 2007; Brockopp 2004). According to Al-Bar and Chamsi-Pasha (2015) and Atighetchi (2007), in Islam, abortion is allowed for certain medical reasons, including a serious disease of the expectant mother that makes continuation of the pregnancy hazardous to her health or even to her life. The mother is recognized as having a greater value than the fetus as a form of life that has already been developed and is possibly the source of a new life. According to the Islamic *Fiqh* Council (Saudi Arabia), in case of a severe congenital anomaly, abortion can be allowed if agreed upon by a committee of experts (Albar, 2007; Al-Bar and Chamsi-Pasha 2015; Al-Matary and Ali 2014).

The normative Islamic literature also upholds the notion of God's omnipotence and omniscience concerning life and death. God is the giver and taker of life (Al-Jeilani 1987; Atighetchi 2007; Brockopp 2008; Fitzpatrick et al. 2016), which implies human limitedness and the human impossibility of predicting one's moment of death (Al-Jeilani 1987; Lapidus 1996; Rahman 1998). In normative Islam we find an unconditional belief in predestination; the occurrence of death is attributed to the will of God (*al-qadr*) (Al-Bar and Chamsi-Pasha 2015; Al-Shahri 2016; Atighetchi 2007; Baider 2012; Rispler-Chaim 1993; Sachedina 2005, 2012; Van den Branden and Broeckaert 2010a). Several scholars (Al-Bar and Chamsi-Pasha 2015; Al-Shahri 2016; Atighetchi 2007; Rispler-Chaim 1993; Sachedina 2005, 2012) argue that God is the creator of everything and the determiner of a person's life span (*ajl*). These arguments are in conflict with a secular right-to-die discourse. Moreover, Atighetchi (2007) states that where the West emphasizes self-determination as a right, from an Islamic perspective autonomy is rather limited, as only God has the right to decide upon a person's life. From this perspective, performing or requesting euthanasia or assisted suicide is perceived as denying God's rights over lives and is seen as an act of blasphemy (Sachedina 2005; Van den Branden and Broeckaert 2010a).

Regarding euthanasia and assisted suicide, normative Islamic and scholarly literature clearly emphasizes a teleological perspective. According to Brockopp (2004) and Van den Branden and Broeckaert (2010a), death, in the Islamic tradition, is merely seen as a transitory element in the larger eschatological scheme, that is, what the soul is awaiting in the hereafter (e.g., paradise; hell). Badawi (2011) and Sachedina (2012) explain that in Islam the purpose of the worldly life is only to prepare a person for the eternal life in the hereafter, as life and illness are viewed as merely a test of God. The future perspective of judgment in the hereafter qualifies a person's action in this world. In Islam, each person has a free will and is thus responsible for his or her own actions (Al-Bar and Chamsi-Pasha 2015; Atighetchi 2007; Rispler-Chaim 1993; Sachedina 2005). Intention (*niyya*) is strongly emphasized in this respect. Atighetchi (2007) and Al-Bar and Chamsi-Pasha (2015) explain that each action will be judged according to the person's intention. Committing suicide would thus result in an eternal punishment in hell (Brockopp 2004; Rispler-Chaim 1993; Sachedina 2012; Van den Branden and Broeckaert 2010a). Through confrontation with illness and suffering, Muslims are recommended to be aware of the earning of good marks (*ḥasanāt*), which pave the road to paradise (Al-Shahri 2016; Brockopp 2004; Rispler-Chaim 1993). In other words, the rejection of active termination of life is to be understood within a broader teleology, within the purposefulness of life and illness. From an Islamic perspective, cultivating a faithful relationship with God and being patient guarantees rewards (*ḥasanāt*) in this life or in the world to come (Al-Bar and Chamsi-Pasha 2015). Baider (2012) also affirms this Islamic perspective by stating that the belief in predestination and the afterlife helps Muslims to cope with severe illnesses. In this teleological and eschatological framework, euthanasia and assisted suicide are not acceptable options.

A final conviction that constitutes an argument against euthanasia and assisted suicide can be found in the sanctity of human life. The *Qur'ān* affirms that all human life is holy (*ḥurm*) and dignified (*karāma*), as God has created it (Al-Bar and Chamsi-Pasha 2015; Al-Shahri 2016; Ghaly 2015). Islam attributes a great value to the preservation of human life. This is one of the five higher objectives of Islamic law (*maqāṣid al-Sharīa*), which entails preservation of faith, life, mind, progeny, and property (Al-Bar and Chamsi-Pasha 2015; Atighetchi 2007; Rispler-Chaim 1993; Sachedina 2009). In Islam high importance is given to taking care of body and life, as they are a trust (*ʾamāna*) of God (Al-Bar and Chamsi-Pasha 2015; Al-Shahri 2016; Ghaly 2015). Several scholars (Al-Bar and Chamsi-Pasha 2015; Atighetchi 2007; Badawi 2011; Brockopp 2004; Ghaly 2015; Rispler-Chaim 1993; Sachedina 2009; Van den Branden and Broeckaert 2010b) corroborate that in Islam the relationship with the body is framed in terms of vicegerency: A human being does not own his or her body, but only has it on loan until death. Life and body are thus considered gifts from God. Therefore, seeking treatment is often considered important. In general, nearly all (*Sunni*) legal schools (*madhāhib*) are of the opinion that seeking remedy is obligatory (*farḍ*) in certain lifesaving situations and in treatable and curable illnesses. A treatment is considered optional or permissible (*mubāḥ*) when the overall benefit is not proven or even doubtful and when the effect of a therapy is uncertain. A therapy is discouraged (*makrūh*) when therapy is futile, when therapy is unlikely to bring benefit, and when harm or even inconvenience from therapy may follow (Al-Bar and Chamsi-Pasha 2015; Al-Jahdali et al. 2013; Padela and Qureshi 2016; Padela and Mohiuddin 2015; Qureshi and Padela 2016; Saiyad

2009). However, the dominant classical position of the *Ḥanbalī* legal school is that seeking medical treatment is permissible but not obligatory and that abstaining is superior. Preference is given for placing trust (*tawakkul*) over seeking medical treatment, and thus refraining from therapy is seen as praiseworthy (Padela and Qureshi 2016; Qureshi and Padela 2016). Euthanasia and assisted suicide, on the other hand, are not an option.

Empirical study

Data collection

We used an exploratory approach to describe the attitudes and beliefs of Moroccan Muslim women regarding euthanasia and assisted suicide. Our goal was to reconstruct Moroccan Muslim's women way of thinking, not to formulate normative judgments about them. From October 2014 to September 2015, 30 semistructured interviews were conducted with a snowball sample of middle-aged and elderly self-identified Muslim women in the Moroccan community in Antwerp, Belgium. This was conducted by the interviewer (first author), who herself is a member of the Moroccan Muslim community. Because of the cultural characteristics of the research population, more specifically the common gender segregation in traditional Muslim societies, in particular among first- and second-generation Moroccan Muslim communities (Timmerman 2001), and the female gender of the interviewer (first author), purposive sampling for qualitative interviewing was limited to Moroccan Muslim women. The views of first-generation Moroccan Muslim men in Antwerp, Belgium, have been addressed by Van den Branden (2006), who additionally conducted a theoretical analysis of Islamic sources on end-of-life-issues (Van den Branden and Broeckaert, 2008). In other words, we chose women of Moroccan descent as this population is one of the largest Muslim communities in Belgium (Hertogen, 2016). Our choice of Antwerp was based on two important reasons. First, this city has the largest Muslim population in Flanders: 19.2% of Antwerp's population is Muslim (Hertogen 2016). Second, Antwerp as a port city is considered to be one of the most multicultural cities in the world. We chose elderly (first-generation) women, as they are, given the aging of this population, confronted with more end-of-life and health care needs. We also included middle-aged participants as they have been brought up in a Western context, in contrast to members of the first generation who grew up in a traditional Islamic context.

Different routes of recruitment (e.g., mosques, women's association, social media) were adopted to incorporate a diversity of profiles within the female Moroccan Muslim community through snowball sampling. Face-to-face interviews were based on a semistructured interview protocol covering the following topics: demographic background, religion, care for the elderly, illness, end-of-life issues, death and dying, mourning, remembrance, and burial. The interviewer (first author) conducted the interviews in *dārija* (Moroccan Arabic), *tarifit* (a Berber language), and Dutch. Participants were interviewed one-on-one (e.g., in their own house, in a room made available by a local nonprofit organization, or in a quiet tea house). To help us with the interpretation of our data, the interviewer (first author) also consulted with 15 experts in the field (e.g., Muslim physicians, Muslim nurses, palliative care consultants, and a *ḥijāma* ["cupping"; a body therapy that purifies that purifies blood by means of a vacuum] practitioner etc.) about euthanasia and assisted suicide between September 2014 and September 2015. The information collected from these interviews provided context within which the data from our interviews could be considered. The data of our interviews with experts are not perceived as normative, but only as a description of their observations and experience with Moroccan Muslims. Experts were interrogated on the same topics as the Moroccan Muslim women via outlined semistructured interview protocols. This approach was helpful as a comparative method to ensure reliability of the data and helped us to be more sensitive toward the data from our interviews.

This study is part of a larger research project on attitudes, beliefs, and practices regarding death and dying among middle-aged and elderly Moroccan Muslim women in Belgium (Antwerp).

Ethics review

Our study was approved by the Social and Societal Ethics Committee (KU Leuven, Belgium). Informed consent was gathered from each participant. In order to guarantee the anonymity of our participants, we made use of pseudonyms.

Data analysis

On average, each interview took 120 minutes (range: 90 minutes to 150 minutes). Data collection continued until theoretical saturation was reached. This occurred after 13 interviews with middle-aged participants and after 12 interviews with elderly participants. Nevertheless, we conducted extra interviews to ensure the validity and reliability of our data. The interviews were audio recorded and transcribed verbatim, using Express Scribe.

Grounded theory methodology (Corbin and Strauss 2015; Glaser and Strauss 1967; Strauss and Corbin 1998) was used to code and analyze the interview data. Grounded theory methodology aims at thoroughly capturing the worldview of the individual respondent as a basis for constructing the worldview of the social group to which the respondent belongs. Therefore, the methodology stresses the use of "taking the role of the other" and the "constant comparative method" as basic research techniques (Glaser and Strauss 1967). By adding codes to the data and through constant comparisons, key concepts—generated inductively—were identified in the interviews, and categories were systematically generated and interrelated to grasp the real-world experiences and meaning systems of our participants.

The data were coded using grounded theory's three major steps of coding: open, axial, and selective coding. During open coding, the data were broken down, examined, and compared in order to identify similarities and differences while categorizing the data. Axial coding, the second step in the coding process, reflected the systematic process we used for grouping data, linking categories based on associative relationships, and deriving conclusions from analysis and resynthesis of data. The third step of coding was selective coding—a process in which relationships between the core category and other categories were systematically identified. This was a process of integrating and refining a theory as an answer to the research question (Corbin and Strauss 2015; Strauss and Corbin 1990). In our exploration of the attitudes and beliefs of Moroccan Muslim women toward euthanasia and assisted suicide, our coding

frame consisted of notions against euthanasia and assisted suicide and notions of dilemma. For example, concepts describing the arguments against euthanasia were "God as author of death," "life as a trust," "blasphemy," "suicide," and "hell." These concepts were subsumed under categories including "theological considerations" and "eschatological considerations," which were subsumed under the category label "contra euthanasia." The data collection was based on constant iterative analysis of each new interview ("theoretical sampling"), which often involved the adaptation and further specification of interview guides. When certain categories were well developed and the relationship between categories was clear, theoretical saturation ("theorizing") was reached (Glaser and Strauss 1967; Strauss and Corbin 1998). A tentative theoretical conclusion was that there was a clear relation between religious beliefs and attitudes toward euthanasia and assisted suicide.

In order to facilitate data analysis, a qualitative data analysis software package (NVivo 10) was used. The data from the interviews with Muslim women and with experts were analyzed separately in an NVivo project. The findings from our interviews with Muslim women were compared with those from the interviews with experts by concept and category and subsequently compared with other empirical studies (cf. Discussion section). Several control measures were taken to ensure reliability and validity of our data and to limit bias. First, all interviews were recorded and transcribed *ad verbum*. Second, the interviewer made use of memos when collecting data and analyzing the data. Third, peer debriefing was performed by the guiding committee, consisting of researchers with an expertise in religious ethics and end-of-life issues. The guiding committee guided and reviewed all phases of the project, from interview guide and research question development, to data collection, data analysis, and dissemination. Double coding was also performed, in which interviews were coded independently by the interviewer and a member of the guiding committee and subsequently compared. Fourth, findings were regularly discussed with several members of the Moroccan Muslim community. Fifth, the data from the interviews with experts in the field, as well as the literature, were used to verify the reliability of our data.

Conceptual framework of treatment decisions in advanced disease

Attitudes toward treatment decisions at the end of life were explored by making use of hypothetical cases (Table 1) that were formulated on the basis of the typology of Broeckaert (Broeckaert 2008; 2009a; 2009b; Broeckaert and Flemish Palliative Care Federation 2006). Broeckaert developed a typology of treatment decisions at the end of life in order to provide clarity regarding ethical dilemmas in end-of-life care. In this typology, choices with regard to euthanasia and assisted suicide constitute one category of treatment decisions (apart from choices with regard to curative/life-sustaining treatment and pain/symptom control). Broeckaert (2009a) distinguishes three kinds of acts belonging to this category: (1) assisted suicide, which means "intentionally assisting a person, at this person's request, to terminate his or her life"; (2) voluntary euthanasia, which is "the intentional administration of lethal drugs in order to painlessly terminate the life of a patient suffering from an incurable condition deemed unbearable by the patient, at this patient's request"; and (3) nonvoluntary euthanasia, which is "the intentional administration of lethal drugs in order to painlessly terminate the life of a patient suffering from an incurable condition deemed unbearable, not at this patient's request." This article is limited to the discussion of assisted suicide and voluntary euthanasia.

Table 1. Hypothetical cases.

Case 1: Assisted suicide
A terminal patient, having only a few more weeks to live, is in severe physical pain. The treating physician has been unable to adequately relieve his/her pain. That patient requests medication to end his/her life. Should the physician be allowed to provide drugs so that the patient can end his/her life?
Case 2: Voluntary euthanasia
A terminal patient, having only a few more weeks to live, is in severe physical pain. The treating physician has been unable to adequately relieve his/her pain. That patient requests his/her life to be ended. Should the physician be allowed to administer a lethal injection?

Results

Participants' (socio-)demographic information and health situations

These middle-aged Moroccan Muslim women ($n = 15$) were between 41 and 55 years old, and the elderly women ($n = 15$) were between 61 and 86 years old. Nearly half of our middle-aged participants were born in Belgium, while the others came to Belgium at a very young age through family reunification. All elderly participants were first-generation migrants who came to Belgium between the early 1960s and early 1990s, in the context of labor migration, family reunification, or marriage migration. Only one elderly participant came to Belgium via an employment visa.

Among our middle-aged participants, 12 were married, 2 were divorced, and 1 was widowed. Among our elderly participants, eight were married, six were widowed, and one was divorced. Our elderly participants had noticeably larger families (with up to 10 children) than our middle-aged participants (up to 6 children).

Among the middle-aged participants, the overwhelming majority were multilingual, mastering a total of three to five languages. Worth noting is that these participants pointed out that they did not have one, but two mother tongues, namely, Dutch and either Moroccan Arabic or a Moroccan Berber language. Among the elderly participants, eight Moroccan Berber women spoke *tarifit* as their mother tongue, while seven Moroccan Arabic women spoke *dārija*. In contrast to the middle-aged participants, they had no or a very limited knowledge of Dutch. Only a small minority of Moroccan Berber Muslim women spoke Arabic, and only two Moroccan Arabic Muslim women had a good knowledge of French.

In Belgium, the majority of the elderly participants and a minority of the middle-aged participants lived a rather isolated life, as most of them had not had the opportunity for education and were illiterate, doing the housekeeping and taking care of their children. Only four elderly participants graduated from

lower secondary school and only one from secondary school. However, a minority of elderly participants had become more socially active at an older age by going to the mosque or sports center and taking Arabic and/or Dutch language classes.

Regarding employment, only two elderly participants worked outside the home as laborers. Much more diversity in socioeconomic status was observed among our middle-aged participants. Nearly half had a high level of education. In contrast to elderly participants, 10 of the 15 middle-aged participants were economically active (from laborers to officials).

Nearly all elderly participants were diagnosed with diabetes and illnesses related to old age, including hyper- and hypotension, knee osteoarthritis, and geriatric migraines. The health issues of our middle-aged participants were limited to knee problems and migraine. Three elderly participants and one middle-aged respondent reported that they had breast or uterine cancer resulting in hysterectomy or mastectomy. One middle-aged participant had heart problems and, as a result of a previous coma, reported a poor health condition. In general, our middle-aged participants reported better health conditions than the elderly participants did. Five middle-aged and four elderly participants reported that they had been confronted with incurable and terminal illnesses within their immediate environment, including Parkinson's disease, dementia, several types of cancer, and severe chronic disease.

Attitudes toward assisted suicide and euthanasia

Case 1: Assisted suicide. Our participants immediately interpreted termination of life from a religious perspective. They all strongly condemned the idea of ending one's suffering in an active and direct way with the assistance of a physician, except for Nuria and Ikram (pseudonyms), who held rather intermediate positions. Nearly all participants unanimously argued that this act is unlawful (*ḥarām*) and is in fact in conflict and irreconcilable with being a believer, a Muslim, and for these reasons it is absolutely unacceptable.

> "No, that's suicide. No, that's *ḥarām*. You may not end your life. No. Being a Christian, a Muslim, or a Jew plays a role. A real Jew, Christian, or Muslim doesn't do that." Hannan—middle-aged—low level of education

> "If it's a non-Muslim, then the physician will give it. It's *ḥarām*! It's not allowed for the soul! […] That's not an Islamic conduct. No, a Muslim may not do that." Yamina—elderly—illiterate

Nearly all participants equated this act with suicide (*intiḥār*), and considered the physician an accomplice. In their opinion, the physician's task was to take care of the patient and not to help the patient with ending his or her life. In this respect, they highlighted that a Muslim is not allowed to express a wish to die. These findings are in keeping with the results of the interviews with our experts.

> "It's still a sort of euthanasia. As a Muslim, I don't accept this, it's euthanasia, it's suicide. It's forbidden to hasten death. You may not wish that." Sarah—middle-aged—high level of education

> "No, they may not give him that. No no, because then he commits suicide. That's *intiḥār* [suicide]. It's not as if someone else gave it to him, but if he does it himself, then it's suicide. It's also not good if a physician does it. The physician is supposed to help a patient and not end his life." Aïcha—elderly—illiterate

> "No no, they see it as euthanasia, because you asked for it. No, it's suicide for both the first- and second-generation Muslim women." Fadila—Psychosocial consultant

A minority of—mainly elderly—participants considered ending one's life prematurely a sign of ignorance (*jahl*), blasphemy (*shirk*), and even disbelief/heresy (*kufr/kfa*). Indeed, throughout the interviews it was argued that a person who commits suicide turns away from God, is ungrateful, and is an unbeliever (*kāfir*).

> "No no, that's not good, that's *jahl* [ignorance]. That's *shirk* [blasphemy]. You may not end your life." Zohra—elderly—low level of education

> "No no, then he stepped out of his religion [*kfa*]. Then he turned away [*kfa*] from God. Someone who does such a thing is not a Muslim, he's a *kāfir* [unbeliever]. It does happen to non-Muslims, for them it's nothing, but for us, this is impossible." Laziza—elderly—illiterate

The strong denouncement of this type of life termination by all our participants is based upon the belief, again shared by all, that only God has the right to end a person's life. This perception has to be viewed against the backdrop of their unconditional belief in the omnipotence of God, who governs over life and death, and predestination. Participants mentioned that only God determines a person's time of death (*ajl*), which is already predetermined. In other words, death is ascribed to God's will (*al-qadr*). They explained that a human being does not have any right to take (any) action to end his or her life, but rather must wait patiently until his or her time of death comes. In this way, humans can score good marks (*ḥaṣanāt*), which will be counted up after death.

> "That's also not allowed! Not at all. […] God decides about your death, your ending. We don't know what God has destined for her. Everything is predestined." Radia—middle-aged—low level of education

> "I don't want anything to do with it. This is not ok. He ended his life before his *ajl*. Like I said, it's God who gives and takes away life. We have no business with that." Malika—elderly—low level of education

Against this backdrop, two participants referred explicitly to the vicegerency of the human being in this worldly life. They explained that life and body have to be taken care of as they are a gift and a trust (*ʾamāna*) from God.

> "Yes, it's forbidden in my religion, so I'm also against it. And as you can see, a body is a gift and if you're sick, it's a part of it. You need to take care of it." Lamya—middle-aged—high level of education

> "Life is an *ʾamāna*. It's only God who can take back his *ʾamāna*." Zohra—elderly—low level of education

In their rejection of assisted suicide (and euthanasia) most participants explicitly referred to their belief in the afterlife, which seems to form a strong barrier against terminating one's

life. Indeed, our participants believed in an eternal afterlife and that life and illness are merely part of God's test for entering the eternal life in paradise. In their opinion, assisted suicide (and euthanasia) entails severe implications in the hereafter. They argued that assisted suicide is merely a relief in this worldly life, but a greater punishment and extreme suffering are awaiting in the hereafter. Moreover, after death, God will judge human beings based on their actions, and this action of taking your own life would lead to an eternal stay in hell, erasing all good deeds that were performed. Therefore, the focus is more on the purposefulness of pain, which is understood as a way of purifying one's sins. This is also confirmed by our experts.

> "We believe in life after death, which is eternal. You know, you're going there and you would want to do everything that's in your power to get there in a right way. Then you're not going to commit suicide. Even if the pain would be really painful." Nihad—middle-aged—high level of education

> "No, that is *ḥarām*. God says: 'the person who commits suicide is destined for hell.' […] And what if you killed yourself in this world, but the hereafter is worse, you'll suffer more in hell? One who commits suicide goes to hell. It's not good. That's my opinion, the one who commits suicide goes to hell, that's what I hear in the *Qur'ān*." Alia—elderly—illiterate

> "I think this almost never happens among us. Because they know you'll be punished severely in the hereafter." Laila—Muslim nurse

Only a few participants nuanced this idea of severe eschatological implications and emphasized that a person cannot pass judgment on another human being's actions. Only God has the knowledge of intentions and can pass moral judgment on a person's actions. Thus, only God possesses knowledge (*Allāhu a'lam*) and therefore knows a human being's destiny.

> "God says that if you commit suicide or jump out of a window or kill someone or take drugs to die, then you'll experience a rough path to God. Where you will go in the hereafter depends upon your deeds. But in this case, it's only God who knows." Khadija—elderly—low level of education

> "If they do that, they'll think they'll have found peace, but they'll not find it. If you commit suicide, you'll go as an unbeliever, as *jahl* to the hereafter. But God knows best [*Allāhu a'lam*]." Fatma—elderly—illiterate

Although we found a strong disapproval of assisted euthanasia among our participants, two participants expressed a more "understanding" attitude toward this case, though they still shared the dismissive attitude toward active termination of life. One elderly participant (Nuria) emphasized the right to self-determination, explaining that a human being has the right to decide for him- or herself, though she still acknowledged that the soul is from God and therefore only God has the authority and power to take away a person's life. Besides Nuria, several elderly and middle-aged participants who did not approve of assisted suicide could actually "understand" the difficulty of dealing with unbearable pain. Our participants also mentioned that they could "understand" that human beings who do not have a faith or do not believe in a God would request assisted suicide. Among them, however, Ikram took an exceptional position. Her answer clearly illustrates a difficult dilemma between the removal of unbearable pain and God's ultimate role in matters of life and death. The notion of compassion fostering a dilemma is also confirmed by our experts. The exceptional answers of Nuria and Ikram are explained later in the Discussion section.

> "Oh [silence]. If the patient decides it, so be it. If he decides it himself. It's his choice. Normally this is not permitted. Like I said before, the soul is from God. Normally we should die naturally." Nuria—elderly—low level of education

> "Yeah, that's terrible. For example, with labor pain I think 'God please!'. You would do anything in that moment. But only God can actually take life. I find it difficult. I don't know what I would do. I really find these extremely difficult situations." Ikram—middle-aged—high level of education

> "There is that emotional aspect on the one hand. They [the family] will have compassion with the patient. And on the other hand, they know we are not allowed to end our lives. So it will be a dilemma either way. But if the pain is unbearable, if you hear a person, constantly screaming in pain, they'll not be able to bear that anymore and it'll be a sort of peace and relief. These are really difficult issues." Nourdin—*'Imām*

Case 2: Voluntary Euthanasia. The participants' opinions on voluntary euthanasia were similar to their views on assisted suicide. All of our participants, except for two (Nuria and Ikram), declared themselves to be absolute opponents of euthanasia, referring to it as a forbidden act (*ḥarām*) and considering it ethically on par with suicide and murder. This was again perceived as contrary to being a Muslim. They believed that Muslims would never commit such an act, and that a Muslim physician would never help terminatie a person's life. In their opinion, requesting euthanasia was considered turning one's back on their faith, namely, turning away from God (*kufr*). They believed that a Muslim should not wish for death. It is worth mentioning that compared with the former case, the physician in this case is not merely viewed as an accomplice, but rather as a murderer.

> "No, a Muslim may not do that. That's *ḥarām*. […] We may not kill ourselves. Because then you have committed suicide. […] God says that you may not kill yourself." Hannan—middle-aged—low level of education

> "Yeah, non-Muslims do that, but we Muslims don't. We may not ask for death. […] That lethal injection is *ḥarām*. The physician should help the patient to live and not to end a life. The physician then killed a soul. We Muslims don't approve of that." Laziza—elderly—illiterate

> "No, absolutely not. There's no one who would approve of that. Because according to Islam it's *ḥarām*, because it's suicide. And I really do not see any difference between those generations." Nora—Muslim nurse

Several participants viewed this act from within an eschatological framework, referring to the encounter with God, paradise, and hell. Here, again, they mentioned eschatological implications when performing euthanasia and explained that it would lead to a severe punishment in the hereafter and thus

would only offer a temporary worldly relief. This idea is also confirmed by our experts. Here, too, a few participants nuanced this idea of severe implications, referring to God as the only one possessing all knowledge.

> "It has also to do with religion. No matter how difficult it may be, how unbearable the pain can be, you say 'there comes an end.' But euthanasia as a Muslim remains difficult because how far is that a liberation? […] If you're a Muslim and you believe that when you die, we'll have an encounter with God, and we'll have paradise and so on." Sarah—middle-aged—high level of education

> "*Allāhu a'lam* [God knows best] but they say that you'll go to hell. But if you do that, I don't know what will happen. Only God knows that." Haddad—elderly—illiterate

> "I think that euthanasia is a step too far. That's suicide. They immediately link it with hell." Soumiya—elderly care consultant

Nearly all participants strongly highlighted that only God has the right to take a person's life, as He is the creator of heaven and earth as well as life and death. Here, too, participants stressed that God determines a person's time of death *(ajl)* and that death only occurs with God's decree. In this respect, participants described God as the ultimate steward of life and body and pointed out the importance of patiently waiting until the time of death comes. In other words, the patient does not have a right to die.

> "Well, no, God has given you a life and He is the only One who may take it away. It's just that Islamic concept of 'God has given you a life, God created you.' You cannot decide when you will be born. You cannot decide when you'll die." Badria—middle-aged—high level of education

> "No no, you'll have to wait patiently until your time comes. […] The moment of death [*ajl*] comes from God. It's God who decides when you'll die, when you'll live. He created us. A human being may not take away his or her life, only God has the right." Zoulikha—elderly—low education

> "They [Moroccan Muslim women] don't do that. They are radically against it. They also believe that death comes from God and that we shouldn't rush into it." Myriam—palliative care consultant

Based upon the belief in an omnipotent God, who has everything in His hands (shared by all), half of our participants also explained their stance against active termination of life on the grounds that God is capable of everything (*al-Qādir*). Hence, they believed that God has the power to cure a person who is declared terminally ill, which as a result fosters hope and the belief in a miracle. This perspective is also closely related to the belief in God's decree (*al-qadr*).

> "That's why I'm against it. And if God doesn't allow it, then there's always a reason why. You know? So that means that there's still a chance of you healing. God is capable of everything." Lamya—middle-aged—high level of education

> "If God wants you to heal, you'll heal. Everything is in God's hands. There's a family member in France who had stomach cancer and the physicians said that they needed to remove his stomach, otherwise he would die. But he refused […]. He's still alive to this day. […] You must have *ṣabr* [patience] and believe in the *qadr* of Allah and perform your prayers." Yamina—elderly—illiterate

Noteworthy is that two participants explicitly pointed out that requesting and performing euthanasia are in fact sacrilege. To them, either the physician (cf. Loubna) or the patient (cf. Alia) was adopting the role of God. In their opinion, God's role as Creator of life and death was denied.

> "I'm against it. I think the physicians are playing God. And I find that sad, because God created us." Loubna—middle-aged—low level of education

> "People don't have a voice in that matter. It's God who'll end his life. If you do that, you're playing God. That's forbidden!" Alia—elderly—illiterate

Two middle-aged participants referred to a tendency in Western societies where aging and incurable illness are equated with a loss of dignity that results in the request for the termination of one's life. They actually feared a "normalization" of euthanasia.

> "Now they tell everyone 'when you have Alzheimer, your life is worthless.' It's like 'oh, no, you don't have a life. You don't know anything anymore.' […] And then the patient will also say 'my life is no life, it's worthless.' […] That's what you're told and it's frightening. Now it's even allowed for children, where do we draw the line? That's frightening." Halima—middle-aged—high level of education

> "Now it's only allowed for severe cases such as terminal illness, but in the long run it'll be for nothing. If they can't handle it anymore, they'll ask to end their life. In the long run it will be seen as a normal act." Narima—middle-aged—low level of education

Here, too, Nuria and Ikram had a different perspective. Similar to the former case, Nuria stressed that every person has the right to decide for him- or herself (self-determination), but at the same time referred to God's role in death. Ikram's answer reflected doubtfulness/incertitude. She was again in a clear dilemma between the difficulty of suffering unbearable pain and the belief in God as the ultimate author of creation and death. Here too, Ikram argued that she would not know what to do in this situation and stated that a human being may not pass judgment on another human being's actions. Several other middle-aged and elderly participants shared their "understanding" for this situation, while at the same time acknowledging that this act is absolutely forbidden. This double perspective is also confirmed by our experts.

> "I find this difficult. In the end we can't judge about it, only God can. So I really don't know, I really have no clue. It would be a nightmare. Imagine that it's your own child or your husband and they can't bear it anymore and they say that they want to die, well, then it's like I end their life. […] But actually, it's God who created him. God will take away his life as He wants. Uhm, I find that difficult. No, I don't think I would do it. I don't know." Ikram—middle-aged—high level of education

> "The decision I make depends on my situation. It depends on what the patient wants. If the patient wants it [euthanasia], he's sick of it and he can't bear it anymore, poor guy, so be it. It's hard. It's God who gives and takes away the soul. Normally we can't interfere in that." Nuria—elderly—low level of education

> "It might be that there are people who suffer so much pain, that they express things that are not allowed. When the pain is so unbearable, they might say 'end it now.' But I think that only max 2% would consider that" Imane—*Ḥijāma* practitioner

Discussion

Cohen et al. (2006a; 2006b) argue that the acceptance of euthanasia tends to increase with the level of education, and tends to decrease with age. However, this was not observed in our study. Although there are differences in age, but also in level of education and socioeconomic status between the first and second generations, surprisingly no differences were observed between our middle-aged and elderly participants in their attitudes toward active termination of life, or between participants who were or were not confronted with severe illness, either personally or in their immediate environment. Although it could be assumed that second-generation Muslim women, who were born or raised in Belgium, are more likely to be influenced by Western ideas, which might result in the decline of a theological understanding and in the development of a more secular, autonomy-oriented approach, this was not the case in our study. On the contrary, middle-aged women emphasized theological and eschatological notions to an equal degree as the generation before them. Indeed, no differences in attitudes were noted between our participants on the basis of age or educational level. The findings of our interviews with middle-aged and elderly Moroccan Muslim women were also identical to those of the interviews with our experts in the field.

Our study showed that our participants are vehemently opposed to both assisted suicide and voluntary euthanasia based upon four arguments, which are strongly consistent with the lines of reasoning found in normative Islamic views and in earlier empirical studies (Van den Branden 2006, 2008; Baeke, 2012). Although these empirical studies contain small samples, we observed a strong consistent line in our findings. First, euthanasia and assisted suicide are considered forbidden acts, equated with suicide and/or murder. We noticed a shift in condemnation from suicide to murder from the perspective of the patient and from accomplice to murderer from the perspective of the physician (case 1 to case 2). Second, our participants strongly emphasized God's omnipotence and omniscience. Studies by Van den Branden and Broeckaert (2008), Kristiansen et al. (2014), and Ilkilic (2014) endorse our participants' line of reasoning that terminating a person's life denies God's role in matters of life and death. Our participants expressed an unconditional belief in an almighty God who is the ultimate author of illness and cure, life and death, and a person's life span (*ajl*) (cf. no right to die). It is not up to a physician to make a medical prognosis of life span or up to a human being to decide upon one's end of life (cf. blasphemy). Based upon this faith in an almighty God who is capable of everything, notions of hope and belief in a miracle were frequently mentioned by our participants. Third, reference was made to the vicegerency of a human being, which implies that human life and body are a trust from God and therefore must be taken care of. Fourth, our participants strongly emphasize a teleological perspective. Based upon their belief in an eternal afterlife (cf. life and illness as a test; day of judgment, paradise etc.), they believe that active termination of life entails severe eschatological repercussions (cf. punishment, hell). Noteworthy is that mainly elderly participants mention that these acts (might) result in heresy/disbelief (*kufr*), but also in an eternal stay in hell. One might deduce from this that elderly participants likely judge more quickly than middle-aged participants. However, several elderly and middle-aged participants were careful and mentioned in this respect that ultimately only God has the authority to judge a human being and possesses knowledge *(Allāhu a'lam*) on the destiny of each human being.

The answers of our middle-aged and elderly participants were very clear: assisted suicide and euthanasia are absolutely unacceptable and in fact taboo that firmly collides with their worldview. Although our participants vehemently denounced active termination of life, we noticed certain divergent positions marked by a more "understanding" attitude. Nearly one-third of our participants adopted an attitude of "compassion" and "understanding" for the situation of the patient, while at the same time acknowledging explicitly that terminating life strongly contradicts Islamic beliefs. A striking finding is that the presented cases constituted a major dilemma for Ikram, a middle-aged participant, who argued repeatedly that she would not know what to do on the grounds of the difficult and sensitive nature of these cases. Ikram's attitude was clearly marked by doubt/uncertainty, but at the same time she explicitly expressed her belief in an almighty God, who governs over life and death. An understanding attitude toward active termination of life based upon the person's right to self-determination was only expressed by Nuria, an elderly participant. Although she strongly believed that decisions about life and death only belong to God, based on the idea that a personal decision remains a matter between God and the patient, she did mention that every human being has the right to decide for him- or herself. This is not surprising, as Nuria strongly viewed Islam and being a Muslim as a private matter between God and herself.

The exceptional views of both Ikram and Nuria might be explained or influenced by their particular interpretation or view of the afterlife. Contrary to the traditional interpretations shared by the other participants, they believed that notions such as the life in the grave and paradise should be interpreted metaphorically. Though she acknowledged the judging role of God (*al-Hakam*), Ikram had her reservations concerning the severity of the punishment in the grave and strongly put forward the image of God as Merciful (*al-Rahīm*). Both Ikram and Nuria stressed that only God has knowledge of the afterlife. Interestingly, Ikram explicitly mentioned that she does not obey God's laws to receive *ḥasanāt* (good marks) in order to enter paradise, but rather to receive God's love now (Ahaddour, Van den Branden, and Broeckaert forthcoming).

> "Yes, I believe that God is All-Merciful and only wants what's best for His people. I repeat, those frightening stories, I take everything with a grain of salt, in which extent it's all true. 'There's a resurrection, there's a moment in the grave where you'll be tormented.' I'm not going to say that I don't believe that, because I've already said I'm Muslim. But I'm not sure if they're a hundred percent sure that it exists. […] I believe that when you die, that if you've done good, that you'll be in some sort of grace. You'll be sleeping and you'll feel good. […] On the other hand I think that Allah is Almighty. He can do everything. […] So I think it's beyond our imagination. It's like error, we cannot grasp it. My mother says 'it all exists, it exists!' She's so sure about that, when I'm not. It remains a mystery."
> Ikram—middle-aged

> "What will happen after death? Of course everyone thinks about paradise. 'There's hell and there's paradise.' I've known this since I was little, but Allah knows best. […] They say that there is punishment of the grave and punishment of hell and that all Muslims go to paradise. But I say that it isn't true. It's not true. […] My idea about this is that when someone dies, he'll become a new person. Voila, for me there will be a change of appearance. God knows best. I don't know if there's a hell. No one has ever returned from the dead to know what will happen." Nuria—elderly

Like us, Baeke and colleagues (Baeke 2012; Baeke, Wils, and Broeckaert 2012) also found a few "understanding" voices regarding euthanasia. Although the exceptional views in Baeke's study were based more upon the argument of self-determination, in our study this argument was only articulated by Nuria, whereas mainly Ikram but also several others expressed the feeling of "compassion" and "understanding." According to Baeke, the image of God might influence one's attitude toward active termination of life. As such, she suggests that "people who perceive God as an almighty, all-knowing, judging God, are more likely to disapprove of active termination of life" (Baeke, Wils, and Broeckaert 2012, 41). Our study suggests that reservations regarding the traditional representation of the afterlife (with a stress on punishment and hell) are influential here. Though in our study Ikram and Nuria still believed in an almighty and transcendent God, they did put the image of God as Merciful forward more than the image of God as Judge.

A second hypothesis suggested by Van den Branden and Broeckaert (2008) and Baeke, Wils, and Broeckaert (2012) is that confrontation with a palliative situation might lead to more openness toward euthanasia. Quite similar to our findings, Van den Branden and Broeckaert noticed that some of their participants, who were confronted with a palliative situation in their personal lives, experienced difficulties in answering the hypothetical cases. While we also found this same difficulty in a few participants (e.g., Ikram), these participants were not confronted with a palliative situation. While Baeke found the already-mentioned hypothesis to be true for her participants Saida and Ayten, this was not the case for her participant Zohra. On the contrary, Zohra, whose husband and sister had died from cancer, radically opposed active termination of life. The participants in our study who were confronted with severe illness themselves or within their immediate environment strongly emphasized, as nearly all other participants did, that only God rules in matters of life and death and that no human person may intervene within that domain, thus ruling out the possibility of euthanasia or assisted suicide. However, we must say that the aforementioned hypothesis does seem to make sense, based on other parts of our research, with regard to our participants' attitudes toward pain relief; there, they seem to show a more open attitude than the other participants.

Other empirical studies with a Muslim sample—of which the majority is of a quantitative nature—endorse our finding that approval is rather exceptional (e.g., Aghababaei 2013; Ahmed et al. 2001; Ahmed, Sorum, and Mullet 2010; Qidwai et al. 2001; Roelands et al. 2015). The explanation that is provided most often for the denouncement of euthanasia is the reference made to religious beliefs. Only a small number of studies among (mostly Turkish) Muslims (in "more secular" Turkey) report a tolerant attitude toward euthanasia (Ahmed and Kheir 2006; Bugay, Sorum, and Mullet 2014; Cavlak et al. 2007; Gard et al. 2005; Koç 2012; Tepehan, Özkara, and Yavuz 2009).

Our findings should be interpreted with several limitations in mind. First, data might be biased due to social desirability. As such, opinions that might deviate from the norm or opinions that could be seen as contrary to Islamic teaching might be difficult to express. As an interviewer, it is difficult to ascertain whether participants share truthful information. Although several measures were taken to guarantee anonymity (e.g., pseudonyms, deleting audio tapes after transcribing), qualitative research cannot fully guarantee anonymity (e.g., face-to-face interviews). Both advantages and disadvantages are attached to the background of the interviewer (interviewer bias). On the one hand, being a member of the same community facilitated the gaining of trust and resulted in a certain openness and detailed conversations, but on the other hand this might also have influenced the answers of the participants, who might not have provided "deviate" answers out of fear of being judged.

Second, a possible bias is the mixed position of the expert between giving technical information and giving his or her own personal view on the matter. During coding, we took this into account and made a clear distinction between personal views and views of Moroccan Muslim women. Experts might have also given socially desirable answers. However, this bias is limited due to the number and diversity in profiles of experts and due to the fact that we specifically interrogated experts on their professional opinion.

Third, the inclusion of the guiding committee also introduced a bias. The interviews conducted in *dārija* (Moroccan Arabic) and *tarifit* (a Berber language) had to be translated into Dutch and English, which might have influenced the data. As this was carried out to ensure validity and reliability so that the guiding committee could follow the coding and analyzing of the data, the first author sought to make accurate translations and verified their accuracy by relying on members of the Moroccan community when confronted with difficulties in the translation of a word or concept. To assure reliability and validity and limit bias as much as possible, we adopted several strategies (e.g., data checking with members of the Moroccan Muslim community; peer debriefing; memos).

Fourth, given the nature of our data (specific groups; small sample sizes), we are prudent in generalizing our findings, and we acknowledge that further in-depth investigations of the matter are necessary. However, our results were confirmed by earlier studies of our research group, as well as the other available empirical studies. Fifth, although we did not include terminally ill patients in this study, we found identical attitudes among our participants who were (still) confronted with aging symptoms or with severe illness (e.g., cancer) themselves or in their immediate environment. However, it would still be interesting to do an in-depth study of Muslim patients personally confronted with terminal illness. Sixth, taking into account the specific situation of first-generation Moroccan Muslims in Belgium characterized by a homogeneous socioeconomic situation and a more diverse sociodemographic background among second-generation Muslims, it would be interesting to explore the views among third-generation Muslims, who are assumed to

embody a stronger diversity socioeconomically as well as religiously. Further studies could explore whether the impact of religion on attitudes toward active termination of life would differ among younger generations of (Moroccan) Muslims who have been brought up in a Western environment and thus have a strong connection with Western society through language, education, and work and who in this context experience and construct their own (religious) identity.

Conclusion

Religious beliefs have an important impact on attitudes toward end-of-life issues. Theological and more specifically teleological considerations centering on God's sovereignty in matters of life and death and the belief in the afterlife seem to be very crucial for Muslims. Strikingly, in our study no differences were observed between middle-aged and elderly Moroccan Muslim women. This can be explained by the fundamental and radical unacceptability of an active termination of life, as it intrinsically denies God's ultimate role in life and death, which was upheld by all our participants, regardless of age or level of education. As a result of these strong beliefs, we observed hardly any differences between the attitudes of our Muslim participants and the lines of reasoning found in normative Islamic views.

Conflicts of interest

None.

Author contributions

All authors included in this article fulfill the ICMJE 2013 criteria of authorship. There is no one else who fulfills this criterion but has not been included as an author.

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