End-of-Life Care with An Islamic Perspective

Authors:

- Dr. Hanzla Tariq, MD (Emergency Medicine)
- Dr. Obaidullah Khan, MD (Family & Emergency Medicine)
- Dr. Ahmad Khan, MD (Palliative Care)
- Dr. M. Hashim Khan, MD (Respirology)
- Dr. Hassan Shahzad, MD (Palliative Care)
- Imam Hamid Slimi, PhD (Islamic Scholar)

Reviewed and approved by:

- Imam Mohammad Iqbal Al-Nadvi, PhD (FMC Chairman)
- Imam Hamid Slimi, PhD (FMC General Secretary)
- Imam Mahmoud Omar, PhD (FMC Member)
- Imam Wael Shihab, PhD (FMC Member)
- Imam Abdalla Idris Ali, PhD (FMC Member)
- Imam Abdul Hai Patel, PhD (FMC Member)
- Imam Saeed Faizi, PhD (FMC Member)
- Imam Faizanul Haq, PhD (FMC Member)

Introduction

Navigating end-of-life care involves complex medical, ethical, and spiritual considerations. This detailed academic paper provides comprehensive insights into medical practices, ethical frameworks, and Islamic guidelines, ensuring informed decisions and alignment with religious beliefs and practices. Very often, when a family member struggles with death and life support, all concerned immediate relatives are faced with the challenge to decide about the situation. We believe this paper will help Muslims insha Allah when making decisions at that critical time before death because it encompasses detailed information written in a simple language giving enough information about different aspects of end-of-life care. Thus, we hope that this work will educate and help ease the usual unintentional tension that is caused by different family members with different perspectives on how to proceed when it comes to doing what is good for a relative in intensive care or on a life sustaining treatment.

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1. Resuscitation and Advanced Cardiac Life Support (ACLS)

1.1 Cardiopulmonary Resuscitation (CPR)

Definition:
CPR is an emergency intervention used when the heart or breathing stops. It combines:

- **Chest Compressions:** Manually pumping the heart to circulate blood.
- **Artificial Ventilation:** Providing oxygen via mouth-to-mouth, bag-valve mask, or intubation.

Risks:
In frail or elderly patients, CPR often results in rib fractures and low chances of neurologically intact survival.

Islamic Ruling: Permissible and even encouraged for conditions that are reversible and to save lives.

1.2 Defibrillation

Definition:
The delivery of an electric shock to the heart to correct arrhythmias like ventricular fibrillation.

Procedure:
Pads are placed on the chest, and an Automated External Defibrillator (AED) or hospital defibrillator delivers the shock.

Islamic Ruling: Electrical shocks and Chest compressions for revival are permissible

1.3 Advanced Cardiac Life Support (ACLS)

Definition:
ACLS builds on basic CPR with advanced interventions like:

- Airway management (intubation).
- IV medications (e.g., epinephrine).
- ECG interpretation and defibrillation.

Team-based Care:
Performed by trained medical professionals in hospitals or advanced care settings.

Islamic Ruling: Permissible and recommended because all medical treatments that aim at restoring health or preventing death are generally encouraged.

1.4 Survival Rates and Risks

Out-of-Hospital Cardiac Arrest:

- ~10% survival to discharge.

In-Hospital Cardiac Arrest:

- ~15–20% survival to discharge.

Outcome Considerations:

- Many survivors are left with neurological deficits or require prolonged life support.
- The benefit of resuscitation declines with age, frailty, and multiple comorbidities.

1.5 Code Status Choices

Hospitals record code status on admission to guide emergency care:

- **Full Code:** All resuscitative measures including CPR and intubation.
- **Do Not Resuscitate (DNR):** No CPR or resuscitative efforts if the heart or breathing stops.

Why It Matters:
Helps ensure care aligns with the patient's wishes, especially during time-sensitive emergencies. These decisions should be part of **Advance Care Planning** (see Section 4).

2. Understanding Life Support and Medical Interventions

2.1 Definition and Purpose of Life Support

Definition:
Life support includes various medical interventions that help sustain life when the body can no longer do so independently.

Purpose:
Often used in critical conditions, life support can temporarily assist breathing, heart function, blood pressure, and other vital functions when faced with a **reversible disease**. It is a vital tool used to stabilize patients, support organ function, and provide time for recovery or further treatment decisions.

Islamic Ruling: Permissible and recommended to save lives but when there is no progress as per the doctors' confirmation it can be removed so the patient could die naturally.

2.2 Indications for Life Support

Life support is used when a patient's vital organs—such as the heart, brain, lungs, or kidneys—fail to function effectively on their own. It is considered when:

- The condition is reversible or manageable.
- The patient has a chance to regain a meaningful quality of life.
- It provides time for recovery or for waiting for a transplant.

Situations where life support is indicated include:

- **Acute Respiratory Failure:** Ventilator support for oxygenation and CO_2 removal.
- **Cardiac Arrest or Cardiogenic Shock:** CPR, defibrillation, vasopressors, and circulatory support.
- **Major Trauma:** Stabilizing organ function post-injury.
- **Traumatic Brain Injury:** To manage intracranial pressure and prevent further injury.
- **End-Stage Organ Failure:** Including lung, heart, or kidney disease (e.g., dialysis as a bridge to transplant).
- **Septic Shock:** To maintain perfusion during systemic infection.
- **Major Surgeries:** Supporting vital functions perioperatively.
- **Drug Overdose/Poisoning:** Assisting the body while it metabolizes or eliminates toxins.

- **Bridge to Transplant:** Temporizing measure while awaiting organ donation.

2.3 Life-Saving and Life-Sustaining Interventions

Life-Saving Interventions:

- **Respiratory Support:**
  - *Invasive Ventilation:* Requires intubation and a medically induced coma.
  - *Non-Invasive Ventilation:* BiPAP or CPAP via face mask.
- **Cardiac Support:**
  - *CPR:* Manual compressions and ventilation to maintain perfusion.
  - *Defibrillation:* Electrical shock to correct arrhythmia.
  - *Vasopressors:* Medications to increase blood pressure in shock.
- **Renal Support:**
  - *Dialysis (e.g., CRRT):* Blood filtration when kidneys fail.
- **Surgical Intervention:** Only when the expected benefit outweighs the risks; many have high mortality even with surgery.

Life-Sustaining Interventions:

- **Feeding Tube:** Nasogastric or gastrostomy for nutrition.
- **IV Hydration:** Maintaining fluid and electrolyte balance.

2.4 Life-Comforting Measures

Palliative Sedation:
Used when symptoms cannot be controlled by other means. Sedation reduces awareness and provides comfort in the final stages.

Islamic Ruling: Allowed to relieve unbearable pain for terminally ill patients so long as it does not hasten or cause death.

2.5 Medically Induced Coma

Purpose:
To decrease metabolic demands and allow recovery of critically stressed organs (brain, heart, lungs).

Mechanism:
Achieved using sedative medications, it places the patient into deep unconsciousness under intensive monitoring.

Risks & Benefits:
While it provides vital organ rest, risks include infection, pressure sores, and deconditioning.

Islamic Ruling: It is permissible to manage pain and sustain life, but it is not allowed if used to hasten death or if the treatment is deemed futile.

3. Substitute Decision-Makers (SDMs)

3.1 Understanding Capacity and Futility

Capacity:
The ability to understand relevant information about treatment options, appreciate how it applies to one's own situation, reason through choices, and communicate a decision while **understanding the risks and benefits**. Capacity is specific to the decision at hand and can change over time.

Futility:
Treatments that only prolong dying or suffering without meaningful benefit are deemed medically futile.

3.2 Role of Substitute Decision-Makers

When a patient lacks capacity, an SDM is legally required to make decisions. The SDM is expected to:

- Follow previously expressed wishes of the patient (substituted judgment).
- If wishes are unknown, act in the patient's best interests, weighing burdens and benefits.

Physician's Role:
Physicians assess whether conditions are reversible and provide recommendations accordingly—interventions are withheld if deemed futile.

3.3 Legal Hierarchy in Ontario

Under the **Health Care Consent Act (HCCA)**, if no Power of Attorney is designated, the SDM is chosen in the following order:

1. Guardian of the person (court-appointed)
2. Attorney for personal care (named in legal document)
3. Representative appointed by the Consent and Capacity Board
4. Spouse or partner (includes common-law of over one year)
5. Child (age 16+) or parent
6. Parent with right of access only
7. Sibling

8. Any other relative
9. Public Guardian and Trustee (PGT), as last resort

Equal Rank Rule:
If multiple people exist at the same rank (e.g., two adult children), they must agree. If consensus fails, the Consent and Capacity Board may intervene.

NOTE: terms may differ in your province (outside of Ontario), please consult local experts.

3.4 Public Guardian and Trustee (PGT)

Role:
Acts as SDM when no suitable family or appointed individual is available. The PGT ensures medical decisions are made lawfully but may not be familiar with the patient's values.

Disputes:
If significant conflict arises among SDMs or with the healthcare team, the PGT can be asked to assume decision-making authority.

3.5 Dispute Resolution through Consent and Capacity Board

When Used:
The Board resolves disputes about:

- A patient's capacity.
- Who should act as the SDM.
- Whether an SDM is acting appropriately.

Process:
Healthcare providers or families may apply to the Consent and Capacity Board. Its decisions are legally binding and prioritize the patient's previously expressed wishes or best interests.

4. Advance Care Planning

4.1 Importance of Advance Care Planning

Definition:
Advance Care Planning (ACP) is the process by which individuals clarify their values and treatment preferences in case they become incapable of making decisions in the future.

Why It Matters:

- Ensures that medical care aligns with a person's goals and beliefs.
- Reduces the emotional burden on family members and decision-makers.
- Avoids unnecessary or undesired interventions.

Islamic Perspective:
Many scholars encourage Muslims to express their healthcare wishes clearly and appoint someone familiar with both medical and religious values.

4.2 Advance Care Directive (ACD)

Definition:
A written statement (also called Advance Directive or Advance Care Plan) outlining a person's preferences regarding treatments like:

- CPR and intubation
- Artificial nutrition and hydration
- Palliative sedation
- Organ donation

Legal Status:
While not always legally binding, ACDs strongly guide SDMs and healthcare providers.

4.3 Power of Attorney for Healthcare

Definition:
A legal document that appoints someone (the attorney or proxy) to make healthcare decisions on your behalf if you lose capacity.

Distinction from a Will:
A will governs property after death. A Power of Attorney for Healthcare governs medical decisions while the person is alive but incapacitated.

Key Considerations:

- Choose someone who understands your medical and spiritual values.
- Have clear conversations about your preferences (including MAiD, palliative care, resuscitation, etc.).

N.B. It is important that instructions are given in a clear fashion by the patient to the person acting on their behalf stating that no MAiD or hastening death will be applied. Likewise, any other procedures that contradict the Islamic teachings should be avoided. This becomes a legal duty on those making the decision on behalf of the patient as they cannot alter or change the patient's instructions.

4.4 Shared Decision-Making Model

Definition:
An approach where patients (or their SDMs) and clinicians make decisions together, considering both medical evidence and the patient's values.

Steps Involved:

1. **Explain Options:** Healthcare providers outline potential treatments and their risks/benefits.
2. **Explore Values:** Identify what matters most to the patient (e.g., comfort, independence, longevity).
3. **Discuss Fit:** Match treatments to patient values.
4. **Agree on Plan:** A consensus is reached on the best path forward.

Why It Matters:
This model empowers patients and fosters trust between families and healthcare teams, especially in culturally diverse and religiously observant populations.

N.B. It is critical from an Islamic perspective to always seek cure and put saving life as a priority in contrast to hastening death. Therefore, the patient or family members must seek the medical expert advice and a second opinion on the matter at hand then discuss it with a religious advisor if guidance is needed. This document could be used as a guiding reference as well.

5. Managing Symptoms

Purpose:
Medications are used in end-of-life care to alleviate symptoms in advanced illness.

5.1 Common Symptoms:

- Severe pain
- Breathlessness
- Emotional Distress

5.2 Opioids and Psychoactive Medications

Types of Medications:

- **Opioids:** e.g., morphine, hydromorphone—relieve physical pain and dyspnea.
- **Psychoactive Drugs:** e.g., benzodiazepines, antipsychotics—used for agitation, anxiety, or delirium.

Concerns in Islam:
Islam prohibits recreational intoxication. However, most scholars permit medically necessary use of these drugs at end of life to reduce suffering, even if they cause sedation or euphoria, provided the intent is therapeutic, not intoxicating or resulting in death.

Key Clarification:

- The goal is comfort, not hastening death or inducing addiction.
- Doses are medically titrated and regularly reassessed.
- Families should be reassured that these drugs are tools of mercy in palliative care.

5.3 Palliative Sedation

Definition:
The deliberate lowering of consciousness using sedative medications to relieve intractable symptoms when all other measures have failed.

Indications:

- Refractory pain
- Dyspnea (severe shortness of breath)
- Existential or spiritual distress

- Agitation unresponsive to treatment

Ethical and Legal Considerations:

- Requires informed consent from the patient or SDM.
- Distinct from MAiD—it does not intend to hasten death.
- Patients under deep sedation typically pass away from their illness, not from the sedation itself.

Islamic Viewpoint:
Islamic scholars generally permit palliative sedation when death is imminent, and the aim is to reduce unbearable suffering without hastening death.

Practical Implication:
Palliative sedation may render the patient unable to eat, drink, or communicate. Its use is carefully considered by the medical team and family.

6. Coma and Consciousness Disorders

6.1 Definition of Coma

Coma:
A coma is a deep, prolonged state of unconsciousness where the patient:

- Cannot be awakened.
- Does not respond to pain, verbal commands, or environmental stimuli.
- May retain basic functions such as heartbeat and spontaneous breathing (often with medical support).

Medically Induced Coma:
Doctors may intentionally induce a coma using medications to protect the brain or other organs during severe illness or trauma. This is closely monitored and reversed once the clinical situation stabilizes.

Islamic Perspective: Medically induced coma may be religiously allowed for a medical necessity.

6.2 Brain Death, Persistent Vegetative State (PVS), and Minimally Conscious State (MCS)

Brain Death:

- Complete and irreversible loss of all brain function, including the brainstem.
- Legally and medically considered death in Canada.
- No breathing or response; organs can be maintained temporarily with machines.

Persistent Vegetative State (PVS):

- The patient appears awake (e.g., eyes open) but lacks awareness.
- Basic brainstem reflexes persist (e.g., breathing, sleep-wake cycles), but higher cognitive functions are absent.
- Movements are reflexive, not purposeful.

Minimally Conscious State (MCS):

- Some evidence of awareness and responsiveness.
- May follow commands, show emotional responses, or engage intermittently with the environment.

Clinical Importance:

- Distinguishing between PVS and MCS is essential, as MCS may have some potential for recovery, while PVS prognosis is typically poor.

6.3 Diagnosing and Managing Persistent Vegetative State (PVS)

Diagnosis:

- Based on prolonged observation (weeks to months).
- Excludes temporary or treatable causes of unconsciousness (e.g., sedation, metabolic imbalances).

Typical Presentation of PVS:

- Eyes open but no purposeful tracking.
- Reflexive movements only.
- No verbal communication.
- Unresponsive to pain in a purposeful way.
- Inconsistent facial expressions (e.g., grimacing, random smiling).
- Presence of sleep-wake cycles.
- Retention of basic reflexes (e.g., blinking, yawning).

Management:

- Artificial nutrition and hydration via feeding tube.
- Prevention of complications: infections, pressure ulcers, and joint stiffness.
- Long-term care planning, often involving family, legal, and ethical consultations.

Legal Note:
In Canada, withdrawal of life-sustaining treatment from a patient in PVS requires consent from an SDM. If there is disagreement, the matter may be resolved through the Consent and Capacity Board.

7. Supportive and Palliative Care

7.1 Palliative Care Services

Definition:
Palliative care is specialized medical care focused on relieving symptoms, stress, and suffering in patients with serious or terminal illnesses.

Scope of Services:

- Symptom management: pain, nausea, breathlessness, fatigue.
- Emotional, spiritual, and psychosocial support.
- Family counseling and bereavement support.
- Coordination with other specialists (e.g., oncology, geriatrics).

Settings:

- Hospitals
- Hospices
- Community and in-home care
- Long-term care facilities

Goals:

- Improve quality of life.
- Support dignity and autonomy.
- Align care with patient values and wishes.

7.2 Hospice and Home Care Options

Hospice Care:

- Facility-based care focusing exclusively on comfort and dignity.
- 24/7 nursing and personal support staff.
- Often provides private rooms and space for family overnight stays.
- Ideal for those lacking adequate home support.

Home Palliative Care:

- Most patients in Ontario receive palliative care at home.
- Services may include:

    - Visits from physicians or nurse practitioners.
    - Personal support workers (PSWs) for bathing, feeding, hygiene.
    - Access to loaned equipment (hospital bed, wheelchair).
    - Medications covered under special “palliative” designations.

7.3 Philosophy and Goals of Palliative Care

Core Principles:

- Care focuses on comfort, not cure.
- Emphasis on the patient's values and quality of life.
- Death is neither hastened nor postponed.

Islamic Perspective:

- Supports symptom relief that enables patients to pray, reflect, and prepare spiritually.
- Emphasizes relieving distress as a form of mercy.
- Encourages holistic care including spiritual counsel and religious observance.

Integrated Support:

- Multidisciplinary teams work to address not only medical needs but also psychological and spiritual dimensions of dying.
- Chaplains or Imams can offer Qur'an recitation, du’a, and religious guidance.

8. Choosing a Place for End-of-Life Care

Selecting an appropriate setting for end-of-life care depends on the patient's medical condition, support system, and personal or religious preferences. The three primary options in Ontario are home-based care, hospital-based palliative units, and hospice facilities.

8.1 Home Palliative Care

Overview:

- Most common setting for palliative care in Ontario.
- Offers familiarity and comfort in the patient's own environment.
- Allows family members to participate more directly in care.

Supports Available:

- Regular visits by palliative care physicians or nurse practitioners.
- Home visits from PSWs for personal care tasks (bathing, toileting, dressing).
- Equipment loans: hospital beds, walkers, oxygen tanks, catheters, etc.
- 24/7 on-call nursing support (in some regions).
- Covered palliative medications through provincial drug programs.

Benefits:

- Promotes peace, privacy, and family bonding.
- Often aligns well with Islamic and cultural values emphasizing home-based death.

8.2 Hospital-Based Palliative Care Units

Definition:

- Designated areas within larger hospitals that focus on end-of-life care.

Features:

- Skilled interdisciplinary teams including palliative physicians, nurses, and social workers.
- Access to emergency medical interventions when needed.

Pros:

- Constant monitoring and immediate response to medical changes.
- Useful for complex symptom management or rapid deterioration.

Cons:

- Less personal environment.
- May lack privacy and can be busy or noisy.

8.3 Hospice Care / Facility-Based Palliative Care Units (PCU)

Definition:

- Standalone residential facilities that provide comfort-focused care for the terminally ill.

Design Elements:

- Private rooms, family accommodations, quiet halls, natural lighting.
- Home-like atmosphere promoting peace and dignity.

Staffing:

- Around-the-clock nursing and PSW support.
- Volunteers often assist with emotional and spiritual support.

Ideal For:

- Patients without sufficient home care support.
- Families who need respite but still wish to remain involved.
- Individuals prioritizing dignity, comfort, and spiritual preparation at life's end.

9. Euthanasia and Medical Assistance in Dying (MAiD)

9.1 Understanding Euthanasia

Definition:
Euthanasia, from the Greek word for “good death,” refers to the intentional ending of a person's life to relieve intractable suffering, typically at the patient's voluntary request.

9.2 Medical Assistance in Dying (MAiD) in Canada

Definition:
MAiD is the legal process in Canada allowing physicians or nurse practitioners to administer or prescribe a substance that causes death at the patient’s request, under strict conditions.

Two Forms:

1. **Clinician-administered MAiD:** A doctor or nurse practitioner administers the drug.
2. **Self-administered MAiD:** The patient takes the medication themselves (less common).

Legal Framework:
Regulated under Canada’s Criminal Code and overseen by Health Canada.

9.3 Eligibility Criteria and Processes

As of March 17, 2021, a person must meet the following criteria:

- **Age & Capacity:** At least 18 years old and mentally capable of making health decisions.
- **Health Coverage:** Eligible for publicly funded healthcare in Canada.
- **Voluntary Request:** Made freely, without external pressure.
- **Informed Consent:** Fully informed of all treatment and palliative care options.
- **Grievous & Irremediable Medical Condition:**
    - Serious and incurable illness, disease, or disability.
    - Advanced and irreversible decline in capability.
    - Enduring physical or psychological suffering that is intolerable.
    - **Mental illness alone** is currently excluded as a qualifying condition until March 17, 2027.

Safeguards:

- Assessment by two independent practitioners.
- Waiting periods (in some cases).
- Right to withdraw consent at any time.

Distinguishing Euthanasia from Other End-of-Life Options:

- **Palliative Care:** Focuses on comfort and symptom relief, not hastening death.
- **Palliative Sedation:** Deep sedation used to relieve suffering—not intended to cause death.
- **MAiD:** Intentionally causes death through medical intervention, with informed consent and legal oversight.

Islamic Perspective: Islam prohibits Euthanasia and MAiD on theological and ethical grounds. Life is considered sacred, and only Allah determines its end. However, withdrawal of futile treatment that merely prolongs dying may be permissible when death is imminent.

10. Islamic Perspectives on Organ Donation

10.1 Living and Cadaveric Organ Donation

Living Donation:

- A living person donates a vital organ (e.g., kidney, part of the liver) to someone in need.
- Islamic ethics permits living donation when:
    - It is done voluntarily.
    - There is no financial compensation.
    - The donor faces minimal risk.
    - The transplant is expected to save or significantly improve the recipient's life.
    - Transplant of sexual organs is not permitted in Islam.

Deceased (Cadaveric) Donation:

- Organs are donated after death, usually when brain death is declared.
- Requires prior consent from the individual or their family.

Medical Considerations:

- **Brain Death:** Most deceased donations occur after brain death, which is considered legal death in Canada and so in Islamic jurisprudence.
- **Cardiac Death:** Less common and has stricter time constraints for organ viability.

10.2 Islamic Ethical Guidelines

Core Principles:

- **Sanctity of Life:** Saving life is a core Islamic value.
- **No Harm Principle:** Donation must not seriously harm the donor or disrespect the deceased.
- **Free Will:** Donation must be voluntary and consented to by the donor; coercion is strictly prohibited.
- **No Sale of Organs:** Organ trading for profit is considered haram (forbidden).

Scholarly Consensus:

- Many contemporary scholars and Islamic councils (e.g., OIC Fiqh Academy, AMJA) accept organ donation as ethically permissible under strict conditions.

- Preference is given to life-saving cases.
- Autonomy and dignity of the donor are paramount.

10.3 Role of Trillium Gift of Life Network (TGLN)

Function:
TGLN is Ontario's official agency responsible for coordinating organ and tissue donation.

Process:

- Healthcare staff notify TGLN when a patient may be a potential donor.
- TGLN representatives approach families sensitively to discuss donations.
- Families are encouraged to honor previously expressed consent (e.g., organ donor registration).

Islamic Considerations:

- Donors and families are encouraged to document their decisions in advance.
- Religious advisors may help clarify permissibility based on individual beliefs.
- Donation is seen by many as a form of *Sadaqah Jariyah* (ongoing charity) if life-saving and voluntary.

11. Autopsy Practices and Islamic Views

11.1 Purpose and Process of Autopsy

Definition:
An autopsy (post-mortem examination) is a medical procedure performed after death to determine the cause of death or to study disease processes.

Steps Involved:

- **External Examination:** Visual assessment for trauma, disease, or identifying features.
- **Internal Examination:** Incisions are made to inspect internal organs. Tissue samples may be collected.
- **Report:** A final report summarizes findings and may aid in clarifying medical conditions for families or public health.

11.2 Islamic Scholarly Consensus

General Ruling:
Islam places high importance on the sanctity and dignity of the human body after death. Unnecessary handling, disfigurement, or delay in burial is generally discouraged.

Permissibility:

- **Mandatory Autopsy:** Permitted when legally required (e.g., suspicious deaths, public health investigations).
- **Voluntary Autopsy:** Only permitted when there is a compelling benefit, such as:
    - Understanding hereditary disease to help living relatives.
    - Advancing medical knowledge that could save future lives.
- **Cosmetic Restoration:** Efforts should be made to minimize visible disfigurement after the autopsy.

Ethical Principles:

- Autopsies without necessity are prohibited.
- Consent from the next-of-kin is usually required unless mandated by law.

11.3 Balancing Autopsy with Prompt Burial

Islamic Imperative:
Burial should occur as soon as possible, ideally within 24 hours of death but if needed it can be extended to another day or two.

Common Concerns:

- Autopsies may delay burial beyond 72 hours
- Concerns about disrespect to the body and interference with religious rites.

Practical Guidance:

- Coroners and hospitals often expedite autopsies for religious families.
- Tayammum (dry purification) or modified ghusl (washing) may be used when the body has undergone extensive procedures and may cause more harm and infection to the body.
- Family members should coordinate early with funeral homes and medical staff to ensure religious obligations are fulfilled promptly.

12. Islamic Etiquette (Adab) at End of Life

Proper Islamic etiquette at the end of life honors the sanctity of the human soul and reflects the values of mercy, respect, and dignity. These practices offer spiritual comfort to the dying and provide a framework for families and healthcare teams to support them appropriately.

12.1 Respecting and Protecting the Deceased

Covering the Body:

- Immediately after death, the body should be covered with a clean white sheet.
- Public viewing or photography is discouraged.

Minimal Handling:

- Only those preparing the body for washing (ghusl) and burial should handle the deceased.
- Non-essential examinations or procedures should be avoided unless medically or legally necessary.

No Removal of Body Parts Without Consent:

- Hair, nails, or organs should not be removed unless for valid medical, legal, or donation purposes and with appropriate consent.

12.2 Guidelines for Quran Recitation and Prayer

Reciting the Qur'an:

- Surah Yā Sīn is recommended to be recited softly near the dying person.
- It serves as a reminder of Allah's mercy and helps spiritually prepare the soul.

Prayer and Dhikr:

- Families are encouraged to offer duʿā' and engage in dhikr (remembrance of Allah).
- Family members or religious guide do *talqin* (reminding the dying person about the *Kalimah*)
- Healthcare teams should respect requests for quiet time during prayer.

Accommodations in Clinical Settings:

- A designated space at the bedside for prayer or recitation should be offered.
- Staff should avoid interruptions during these final spiritual rites when possible.
- It is recommended to position the dying person towards Qiblah (direction of Makkah) if it is feasible.

12.3 Visiting Etiquette

Visiting the Dying:

- Highly recommended in Islam. The Prophet ﷺ said: *"Visit the sick, follow the funeral, and feed the hungry."*
- Visitors should speak gently, sit calmly, and make sincere duʿā' for healing or ease in dying.

What to Avoid:

- Overcrowding the room.
- Emotional outbursts that may distress the patient.
- Playing music or making non-religious noises during final moments.

Focus on the Living:

- Greater merit is placed on comforting the ill person while they are alive rather than only mourning after their death.

13. Burial Procedures

Respectful and timely burial is a core obligation in Islamic tradition. The following steps help families and care providers ensure proper religious and legal procedures are followed after death.

13.1 Immediate Steps After Death

If Death Occurs at Home:

- Call emergency services (911) for official pronouncement of death by a paramedic or physician.
- Notify next-of-kin and the chosen funeral home.
- Arrange for body transfer through a licensed funeral service.

If Death Occurs in Hospital:

- The treating physician pronounces death and completes death-related paperwork.
- The body is transferred to the hospital morgue until the funeral home retrieves it.
- The family may be offered a brief private visitation before removal.

Legal Documentation:

- The funeral director assists with obtaining the death certificate and registering the death with provincial authorities.

13.2 Washing (Ghusl) and Shrouding (Kafan)

Ghusl (Ritual Washing):

- Performed by 2–4 adult Muslims of the same gender as the deceased.
- Involves washing the body respectfully with water, often scented, while maintaining privacy and dignity.

Kafan (Shrouding):

- The body is wrapped in plain white cloth (usually three pieces for males, five for females).

- The process is done with reverence, invoking prayers and maintaining full body coverage.

Modified Rituals (When needed):

- If there are open wounds, surgical sites, or autopsy incisions, full ghusl may not be feasible.
- If possible, washing could be applied but without rinsing to avoid opening the wounds.
- In such cases, tayammum (dry purification with clean earth) or wiping over the body with cloth is permitted. If washing will not affect a specific wounded area, then Ghusl can be done.

13.3 Timing and Legal Considerations

Timeliness:

- Islamic tradition encourages burial within 24 hours.
- Delays (e.g., awaiting distant family, coroner investigations) may extend burial up to 72 hours but should be minimized.

Funeral Home and Imam Coordination:

- Choose a funeral home experienced in Islamic burial practices.
- Contact a knowledgeable local Imam for guidance and to lead Janāzah (funeral) prayer.

Additional Considerations:

- Ensure the body is not embalmed unless required by law.
- Avoid unnecessary autopsy or organ removal unless consented and ethically justifiable.
- Avoid moving the body to another country as it may delay the burial process. Consideration for exceptional cases may be accommodated such as cases of fear of interference with the cadaver or desecration…etc.,
- Ensure that the burial place is safe and monitored to avoid any form of desecration of a grave or a corpse. In Canada, it is an indictable offense (up to 5 years in prison) for neglecting duty, improper interference, or indignity. In the USA: Often a felony (e.g., Class 6 in Virginia), with potential for 7+ years imprisonment in some jurisdictions.

- Exceptions: Authorized but limited activities like autopsies, forensic examinations, or organ donation

Summary

This comprehensive academic reference paper covers essential topics concerning end-of-life healthcare decisions, combining medical information with Islamic ethical perspectives. It discusses medical interventions, decision-making frameworks, pain and comfort management, consciousness disorders, euthanasia, organ donation, autopsy practices, supportive care options, Islamic etiquette, and burial procedures, ensuring patients, families, and healthcare providers are equipped to navigate end-of-life care decisions effectively.

For religious concerns and questions, the Fiqh Majlis of Canada (FMC) welcomes any inquiry for more clarification. If there are any points that are missing or we failed to discuss in this paper, please let us know so we can add them.

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بسم الله الرحمن الرحيم

الحمد لله والصلاة والسلام على رسول الله وآله وصحبه ومن والاه

In the name of Allah, the Most Gracious and the most Merciful
May Allah's Blessings and Peace be showered
on His Prophet Muhammad, his family and those who follow his path.

After multiple meetings for review and discussion of this critical subject amongst the members of the Fiqh Majlis of Canada as well as the esteemed professors and doctors of medicine, we hereby approve this very well researched and structured document. We are pleased that all our comments and concerns have been addressed and included in this document and we look forward to more work with our Muslim doctors to address many their issues for us to provide more guidance to the members of our Muslim communities.

We pray to Allah (swt) to accept all the dedicated hours of research and efforts of the authors and the reviewers.

Jazakumu Allahu khayran!

Signed on behalf of the FMC Members: _____

Dr. Muhammad Iqbal Al-Nadvi
Chairman, Fiqh Majlis of Canada

Imam Hamid Slimi, PhD (FMC General Secretary)
Imam Mahmoud Omar, PhD (FMC Member)
Imam Wael Shihab, PhD (FMC Member)
Imam Abdalla Idris Ali, PhD (FMC Member)
Imam Abdul Hai Patel, PhD (FMC Member)
Imam Saeed Faizi, PhD (FMC Member)
Imam Faizanul Haq, PhD (FMC Member)