Journal of the British Islamic Medical Association

Advocacy

Vol 21 - No. 7 | December 2025 | www.jbima.com

Assisted Dying in the United Kingdom: Ethical Complexity, Vulnerability, and the Responsibilities of Muslim Healthcare Professionals

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Introduction

The debate surrounding physician assisted suicide — also known by the terminology of 'assisted dying'— has intensified in the United Kingdom over the past decade. At the time of writing, there is increasing momentum towards legalisation with bills progressing through both the Scottish and Westminster parliaments. These developments have profound implications not only for clinical practice but for the ethical framework through which Muslim healthcare professionals navigate their duties, as well as for the broader Muslim community in Britain.

The Current Legal and Social Landscape

Physician assisted suicide remains illegal under the Suicide Act 1961 in England and Wales, with similar prohibitions in Scotland and Northern Ireland. Despite this, legislative initiatives continue to emerge. The Assisted Dying for Terminally Ill Adults (Scotland) Bill has progressed through parliamentary scrutiny, and may complete the process for legalisation in February/March 2026. Powerful and well-funded advocacy groups continue to lobby for legal change in England and Wales, emphasising autonomy and relief from suffering as core arguments. The Isle of Man jurisdiction has already approved legislation, signaling the possibility of a future in which assisted dying is lawful in certain UK regions while remaining prohibited in others. These variations will challenge clinicians to navigate complex legal and ethical landscapes. [1, 2]

Attitudinal surveys suggest that British society broadly supports the right to physician assisted suicide in principle, reflecting prevailing secular values around individualism and autonomy. However, public debate and opposition groups' challenges have largely centred on practical implications rather than moral objection. Key concerns include ensuring robust safeguards to prevent abuse, the appropriateness of eligibility criteria such as terminal illness, prognosis estimation or mental capacity, protecting vulnerable populations from subtle coercion, establishing clear professional responsibilities for clinicians, and whether 'assisted dying' may even reflect true choice in a health and social care system that is under severe pressure and unable to deliver equity of healthcare experience to all. These practical challenges underscore the complexity of translating societal support into safe and ethically sound legislation.

Vulnerability, Burden, and the Perception of Indignity

Alongside notions of choice and autonomy, at the heart of the assisted dying debate are profound human concerns about suffering, vulnerability, and dignity. Many individuals seeking physician assisted suicide cite fears of being dependent, a burden to family or society,

enduring suffering or an undignified death. Research has demonstrated that these perceptions are as influential as physical pain in motivating requests for assisted death[3].

For Muslim healthcare professionals, these concerns resonate deeply with Islamic ethical principles. The Qur'an emphasises the sanctity of life: *"Do not kill yourselves [or one another]. Indeed, Allah is to you ever Merciful"* (Qur'an 4:29). Human life is viewed as a sacred trust, a gift from God to be valued in all states and protected. The Prophet Muhammad (peace be upon him) said: *"There should be neither harming nor reciprocating harm"* (Sunan Ibn Majah, 2340), highlighting the ethical imperative to alleviate suffering without actively ending life.

The challenge lies in responding to vulnerability in a manner that honours human dignity without compromising these principles. Muslim clinicians may well encounter patients whose requests for physician assisted suicide are framed less by autonomous desire and more by social or psychological pressures, highlighting the intersection of medical, ethical, and societal considerations[4].

Implications for Muslim Healthcare Professionals

For Muslim clinicians, legalised physician assisted suicide is likely to raise complex moral and professional questions. Islamic bioethics maintains that life is a trust from God, and deliberate termination is generally impermissible. Physicians holding this ethical conviction face a quandary due to potential professional obligations and healthcare setting expectations relating to assisted dying.

Conscientious objection frameworks in the UK recognise the right of clinicians to decline participation in procedures conflicting with their moral or religious beliefs, provided patient care is not compromised. However, real-world application is nuanced and the definition of participation is unclear when considering initial patient request discussions, clinical assessments for eligibility, participation in multidisciplinary meetings and referral pathways. Clinicians will need to navigate these boundaries carefully to avoid compromising either professional duties or personal convictions[5].

Muslim healthcare professionals also face broader societal implications. The introduction of assisted dying may prompt complex discussions around palliative and end of life care in multicultural care settings where medical institutional mistrust may be heightened by the fear of physician assisted suicide. Muslim clinicians are called upon to model ethical and compassionate care in ways that reinforce trust between communities and the wider healthcare system. In addition, there will be a need for clinicians to advocate on behalf of the communities they serve by ensuring any ensuing inequality of health and end of life care outcomes are captured and addressed by the healthcare structures they work within.

The Role of the British Muslim Healthcare Community and Wider Muslim Society

If physician assisted suicide becomes legal, the British Muslim healthcare community will need to respond with integrity, ethical clarity, and compassion. This response should be multi-dimensional:

Clinical Practice: Muslim clinicians must balance legal responsibilities with ethical principles. This may involve careful navigation of conscientious objection while ensuring that patients receive unbiased, safe, and respectful care. Attention to the psychosocial and spiritual, existential dimensions of vulnerability is essential. The Qur'an reminds believers: *"And We have certainly honored the children of Adam"* (Qur'an 17:70), affirming the duty to treat all human beings with dignity, especially during moments of fragility and distress.

Community Education and Engagement: Beyond the clinical environment, the Muslim community must engage in sensitive and thoughtful dialogue about the implications of physician assisted suicide. This includes fostering understanding of the moral, social, and medical dimensions of the issue, and developing a communal vision and approach that supports, empowers and honours those who care for society's most vulnerable members.

Promoting Compassionate End-of-Life Care and Ethical Leadership: The Muslim community can emphasise and provide material support in the development of alternatives to assisted suicide that preserve dignity and relieve suffering for all members of society, such as palliative care, hospice support, and psychosocial interventions. By demonstrating the practical, societal and ethical fruits borne from exemplary care and advocacy rooted in the deep value of mercy (*rahmah)*, Muslim clinicians and community leaders can help mitigate fears about vulnerability and dependency without compromising ethical commitments.

Conclusion

Physician-assisted suicide is more than a legal or medical question; it reflects deep and enduring societal anxieties about vulnerability, dependency, and human dignity. For Muslim healthcare professionals, responding to a healthcare landscape in which assisted dying may be legalised requires more than procedural compliance.

It calls for moral clarity, a sustained commitment to compassionate care, and ethical leadership that contributes meaningfully to wider societal discourse.

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