

## Cancer Ethics from the Islamic Point of View

Farzaneh Zahedi<sup>1</sup> and Bagher Larijani<sup>2</sup>

<sup>1</sup>Endocrinology and Metabolism Research Centre, *Medical Sciences/ University of Tehran, Iran*

<sup>2</sup>*Medical Ethics and History of Medicine Research Centre, Endocrinology and Metabolism Research Centre, Medical Sciences/ University of Tehran, Iran*

### ABSTRACT

The approaches to cancer management are changing and the patients are living longer. However there are various ethical issues that cancer patients and families are facing in the health care setting.

In this paper, along with cancer ethical issues, we are going to explain Islamic viewpoints with referring to some cases. We obtained the data by searching databases in PubMed, IranMedex, Ovid sources and some other relevant articles and books.

We will discuss themes of truth-telling, informed consent, end of life issues, decision-making for the seriously ill patients, advance statements about treatment (Living wills), allocation of recourses, research ethics, screening programs, cancer genetics and epidemiological studies. Then the Islamic views will be stated considering two cases.

This review intends to provide health care professionals a basic knowledge about the main issues in cancer ethics in order to facilitate their decision-making in clinical practice.

**Key words:** Cancer; End of life; Islam; Medical ethics; Truth-telling

كُلُّ نَفْسٍ ذَائِقَةُ الْمَوْتِ وَنَبَلُّوكُم بِالشَّرِّ وَالْخَيْرِ فِتْنَةً وَإِلَيْنَا تُرْجَعُونَ (انبیاء/ ۳۵)

"Every soul shall have a taste of death; and We test you by evil and by good by way of trial, to Us must you return" (Holy Koran 21:35).

### INTRODUCTION

There are various ethical issues that can affect patients and families in the health care setting. There are also many complex issues in the field of cancer diagnosis and management. Some of these are raised by the new possibilities in technology. Progress in cancer

care and cancer prevention would arise from advances in genetics, genomics, proteomics, cell biology, immunology, molecular epidemiology, bioinformatics; and behavioral sciences. The approaches to cancer management are changing and the patients are living longer. They are increasingly able to articulate the problems of painful illness and look for more effective solutions to achieve a better quality of life. The shift from curative to palliative care, the context of care (e.g. hospital, hospice, home), and the relationship between ethical and clinical considerations are among main

---

**Corresponding Author:** Bagher Larijani, MD ;  
Medical Ethics and History of Medicine Research Centre,  
Endocrinology and Metabolism Research Center, Medical  
Sciences/University of Tehran, 5th floor, Shariati Hospital, North  
Kargar Avenue, Tehran 14114, Iran, Tel: (+9821) 802 6902-3,  
Fax: (+9821) 802 9399, E-mail: emrc@sina.tums.ac.ir

issues of practical concern in cancer care.

In this paper, we aim to consider cancer ethical issues and explain Islamic viewpoints through some cases. In order to compile the article, we obtained the data by searching databases in PubMed, IranMedex, and Ovid sources. Then we completed our searches via checking the reference lists of the papers and hand-searching relevant journals and books.

### CANCER ETHICS CHALLENGES

Ethics might be considered at various levels of public policy, institutional, professional and personal values and responsibilities. For decision making in the field of bioethics, there are main principles such as autonomy, justice, beneficence and non-maleficence; even though their interpretation and practical application might be different in various communities. Therefore, we need community-based principles and procedures. Due to high prevalence of different kinds of cancers, cancer ethics is a necessary issue in medical ethics. Currently, truth-telling, informed consent, confidentiality, end of life issues, decision-making for the seriously ill patients, advance statements about treatment (Living wills) and the nature and the role of hope in palliative care are main issues of cancer ethics.

The debate on truth telling is at the core of contemporary biomedical ethics. Differences in truth telling arise from the delicate interplay between autonomy and beneficence in medicine, under the influence of cultural variables.<sup>1</sup> In a cancer patient, sometimes physicians must decide whether patients should be informed the truth about their diagnosis and prognosis or not. For many patients, cancer might be considered as a reminder of death. It is remarkably difficult to talk about death and its meaning.<sup>2</sup> Some believe that the patient should be encouraged to make appropriate arrangements for personal matters. For instance, a patient needs time to set his life in order to make a will, take a trip, and so on. Some patients not only want to be free from pain and suffering as they die, they also wish to have the opportunity to make peace with God, to resolve personal conflicts, and to make financial plans before death.<sup>3,4</sup> Disclosure of information to family is another issue. Clinicians may lack training, knowledge, and experience in giving bad news. Formal training communication skills and

increasing availability of a wide variety of resources on communication can enhance the clinician's ability to relay difficult information.<sup>4</sup>

Giving bad news is a difficult task and requires physician competence and facility with communication under stressful circumstances.<sup>4</sup> Involving the patient and family in decision making enables them to have as much control as possible over the dying process. All of these discussions should be both compassionate and culturally acceptable.<sup>4</sup> It is worth noticing that truth telling about prognosis and about statistical predictions in cancer patients is still largely debated in all countries.<sup>5-9</sup> Despite persistent cultural resistance, the shift in truth-telling attitudes and practices in the world appears to reflect a genuine growing tendency towards self-governance in medicine and in life.<sup>10</sup>

Nowadays, doctor is no longer the sole determiner of the patient's best interests and the standpoint of paternalism is not acceptable in many situations and by lots of patients. Certainly, we cannot assume that all patients have similar goals and values. But according to "Paternalistic benevolence", doctors must be selective about options, be vague about diagnosis or prognosis, maintain a positive attitude and knowingly protect the patient from the distressing truth. In contemporary medical ethics, to respect autonomy, it is required to present all the options, telling the patient everything and risking distress.

**Case 1:** A 69 year-old man, estranged from children, no other relatives. Doctor discovers inoperable prostatic cancer. Patient is about to go on holiday to Australia and is very excited. Cancer is slow-growing, renal function is normal; patient would have no problems while in Australia. He was hospitalized for depression after his wife died of cancer.

↳ The doctor lied about situation to the patient. Was he right?

Informed consent is now seen as a legal and ethical requirement for all physicians. But sometimes patients lack sufficient capacity to make autonomous decisions. Nearly 60-70% of seriously ill patients are unable to speak for themselves when the time comes to decide whether or not to limit treatment.<sup>11</sup> It is the physician's role to share decision making with patient, her/his family, surrogate or advocate.

Decision making in terminal care is a demanding and stressful duty for all involved, particularly for a doctor to end patient's life. End of life issues are one of the top 10 health care ethics challenges facing the public in Canada (Table 1).<sup>12</sup>

## Cancer Ethics from the Islamic Point of View

**Table 1. Top 10 Ethical Challenges Facing Canadians in Health Care**

Rank	Scenario
1	Disagreement between patients/families and health care professionals about treatment decisions
2	Waiting lists
3	Access to needed health care resources for the aged, chronically ill and mentally ill
4	Shortage of family physicians or primary care teams in both rural and urban settings
5	Medical errors
6	Withholding/withdrawing life sustaining treatment in the context of terminal or serious illness
7	Achieving informed consent
8	Ethical issues related to subject participation in research
9	Substitute decision–masking
10	The ethics of surgical innovation and incorporation new technologies for patient care

Defining death, the sanctity and “value of life”, the idea of “quality of life”, withdrawing and withholding life-prolonging treatments, and euthanasia are the most important ethical and legal issues in this field. Studies of attitudes of medical professionals towards end-of-life decision-making have been undertaken in many countries.<sup>13</sup> End-of-life care is defined as “the active, total care of patients whose disease is not responsive to curative treatment”.<sup>14</sup> The philosophy of this care is to attain maximal quality of life through control of the myriad physical, psychological, social, and spiritual distress of the patient and family.<sup>4</sup> Advocates working to improve care for dying patients try to determine what elements are necessary for a “good death” to Adequate pain and symptom management, avoiding a prolonged dying process, and clear communication about decisions by patient, family and physician are the main elements.<sup>15-17</sup> Certainly, a good care for dying patients encompasses attention to spiritual issues at the end of life.<sup>18</sup>

For cancer patients at the end of life, the suffering can be a justified reason that the option of ending one’s life through either euthanasia or physician assisted suicide may appear to be a merciful choice. Euthanasia, which is discussed widely in cancer patients, is an act

where a third party, usually implied to be a physician, terminates the life of a person; either passively or actively.<sup>19</sup> Passive euthanasia is often thought of as a “allowing a person to die”. Active euthanasia requires performing some action that terminates the life of a person. The main distinction between physician assisted suicide and active euthanasia is that the doctor is not the person physically administering the drugs. Euthanasia is performed worldwide, regardless of the existence of laws governing it. Respect for human autonomy, “Right to Die” and compassion and sympathy to the terminally ill patient are the main reasons of proponents.<sup>20</sup> But the opponents argue terminating human life is unethical because it violates the moral belief that life should never be taken intentionally.<sup>19</sup> On the other hand, the risks and harms outweigh the benefits.<sup>21</sup> There is also an apprehension of “Slippery Slope”.

According to the British Medical Association (BMA) Guideline, the primary goal of medicine is not to keep patients alive as long as possible but rather medicine aims to restore or maintain patients' health by maximising benefit and minimising harm.<sup>22</sup> The BMA does not believe that it is appropriate to prolong life at all costs, with no regard to its quality or the burdens of the intervention.<sup>22</sup>

Withholding and withdrawing treatments (WH/WD) have raised deep debates in different communities. Cardiopulmonary resuscitation (CPR), mechanical ventilation, and nasal-gastric feeding tubes are lifesaving for some patients, but sometimes they only prolong process of dying. Clinically, the American Medical Association does not distinguish between nutrition and hydration and other life sustaining treatments.<sup>23</sup> Proportionality is the main debate in this issue. For instance, decision making about ICU treatment for the patient with a metastatic cancer should be informed by available knowledge about prognosis. Potential benefits of critical care for the patient with cancer must be weighed against burdens that may be associated with such treatment.<sup>4</sup> The costs of treating cancer patients in ICUs are considerable for the health-care system as a whole. ICU patients account for almost 20% of the average hospital’s operating budget, but only 5 to 6% of total patient days and, among patients consuming the most expensive ICU resources, mortality rates are particularly high.<sup>4,24</sup> Medically futile

treatments are those that are highly unlikely to benefit a patient.<sup>19</sup> The biggest concern is that necessary treatments will be labeled futile in order to save money.<sup>19</sup>

**Case 2:** Mr. B has widely metastatic cancer and has been in a nursing home for 3 months. The consensus of opinion from the medical team is that, if Mr. B has a cardiac arrest while on the ward, resuscitation would not be appropriate. This is because it is highly unlikely to be successful and because he will die very shortly from his cancer. His family state that it's time for dad to be vented. They want everything done for him.

Pain is often a major symptom of terminal patients with cancer. Some considerations about pain control should be emphasized; for instance, sedation toward dying is an important issue. By means of sedation, death might be anticipated in hours to days. There might be intentional physician contribution to death and it is easy to abuse. We have to point out "doctrine of double effect". An act which has two effects, one beneficial and one harmful, it is not morally prohibited if the harmful effect is not intended. There is a morally distinction between intended effects and foreseen effects.

During critical illness, most patients lack decision-making capacity. Advance directives (or Living Wills) aim to honor autonomy and respect individual choice. But advance directives may improperly influence health care providers to limit care (under-treatment). In addition, a person frightened of becoming disabled or incapacitated may use advance directives to limit treatment. On the other hand, advance directives may not be useful if a medical treatment decision requires an immediate answer. Some studies found that the presence or absence of the advance directive had little or no impact on the "pattern of care" of seriously ill patients.<sup>4,25,26</sup>

Other key issues in cancer ethics consist of resource allocation, research ethics, screening programs (such as genetic testing) and prevention of cancers, special issues relating to the care of children, the role of religious belief in ethical debate, the physician's responsibility for psychologic management of patients and their families, and responsibilities of nurses.

Decisions about allocation of resources, particularly in developing countries, would be taken in three levels of Micro-allocation (which individual gets which goods

or services), Macro-allocation (which health care services should be available); and Mega-allocation (what percentage of society's resources should be spent on health care). Distributive justice is an important consideration.

Cancer research ethics is an important challenge in this field. There is a conflict between raising false hopes and possible toxicity causing patients to refuse treatment. Basic principles for ethics, national and International codes and guidelines should be enforced when research protocols are designed.

There are various ethical issues in cancer prevention. Genetic screening for cancer risk is accompanied with some ethical issues, for instance; genetics complexity and heterogeneity, no standards for test characteristics, limited capacity for genetic counseling, lack of effective prevention (or treatment), no guarantee against discrimination, business aspects (patents on genes/tissues), and confidentiality about databases.

Cancer genetics and epidemiological studies of genetic are highly competitive areas of research. As it is obvious, genetic information differs from other health care information in that it is predictive in nature, although the degree of certainty varies, and it always involves at least family members.<sup>27</sup> Most of the international guidelines and recommendations stress the importance of informed consent.<sup>27-32</sup> A preliminary moral question is whether it is ethically justified to pre-symptomatically test for late onset disorders when effective preventive and/or therapeutic measures are not available.<sup>27,33</sup> The World Medical Association recommends that 'this type of diagnosis for a predicted condition be performed only when a therapeutic or prophylactic remedy is available or when an estimate of the risk of transmission can assist parents in making reproductive decisions'.<sup>34</sup> Many hold this view that this position is too restrictive because this recommendation neglects that individuals at risk may have good reasons to apply for the test even if they do not plan to have a family and if therapeutic or prophylactic remedies are not available.<sup>33</sup> However, giving people any information on genetic analyses and possibilities to personal risk for diseases in any case should be linked to personal counseling.<sup>27</sup>

Currently, direct marketing of some types of genetic testing to the public has been introduced in the UK and

## Cancer Ethics from the Islamic Point of View

the USA.<sup>33,35</sup> There is a real danger that unscrupulous companies may prey on the public's fear of disease and genetic disorders and offer inappropriate tests, without adequate counseling and even without the laboratory facilities necessary to ensure the tests are conducted accurately.<sup>33</sup> Education of both the public and the professionals is essential, and should pay due attention to the psychological, societal, and ethical aspects.<sup>33</sup>

Other issues in the field of cancer ethics consist of research in foreign settings (particularly in developing countries), consent in human subjects research, specially in cross-cultural studies, financial conflict of interest for investigators, intellectual property, contracts and grants administration.

### Religious Aspects and Discussion

There is a growing religious concern about bioethical issues in different societies. In the field of cancer ethics, there are a number of definite opinions from the Islamic point of view. According to the Muslim's belief, pain is a form of test or trial, to confirm a believer's spiritual station. *"Every soul shall have a taste of death; and We test you by evil and by good by way of trial, to Us must you return"* (Holy Quran 21:35). However, in Islam, health-care providers must do everything possible to prevent premature death. Therefore, life-saving equipment cannot be turned off unless the physicians are certain about the inevitability of death.

## DISCUSSION

**Case 1:** In such a case, making an ethical decision depends on conceivable therapeutic approaches, patient's outlook on life, and also competency and emotional maturity. The doctors do not have any right to lie to the patient but they are not obliged to tell the whole truth. For instance, the doctor could emphasize necessity of more medical evaluations and could ask the patient to follow. But if there is any expectation about more chance of survival or a better quality of life in the future, telling the truth must not be waited in no way. From the Islamic point of view the first duty of physicians is safeguarding their patients' life, even though they must pay necessary attention to emotional and psychological health of them.

According to Muslims' belief, terrestrial life is sacred because God is its origin and its destiny. The verses of the Holy Quran says: *"Do not take life which God has made sacred except in the course of Justice"* (Holy Quran 6:151), and *"anyone who has killed a fellow human except in lieu of murder or mischief on earth, it would be as he slew the whole mankind"* (Holy Quran 5:32).

**Case 2:** Muslims believe that death does not happen except by God's permission; *"It is not given to any soul to die, save by the leave of God, at an appointed time"* (Holy Quran 3:145). There is no immunity in Islamic law for the physician who unilaterally and actively decides to assist a patient to die; but delaying the inevitable death of a patient through life-sustaining treatment is neither in the patient's nor the public's best interests because of limited financial resources. Withdrawal of life-sustaining treatments in such instances is seen as allowing death to take its natural course.

One of the important religious issues is that the death never concerned as an annihilation and deficiency.<sup>36</sup> According to Holy Quran (32:11); *"The angel of death, who is given charge of you, shall cause you to die, then to your Lord you will be returned"*. Likewise, the Islamic *Shari'ah* does not recognize a patient's right to die voluntarily because life is a divine trust and cannot be terminated by any form of active or passive human intervention, and because its term is fixed by an unalterable divine decree. In Islam, suicide is also absolutely prohibited. In the light of divine religions, nobody has the right to determine his or her life, but has the autonomy to do what he or she wants to improve the quality of the life. We read in Holy Quran that *"O you who believe! Seek assistance through patience and prayer; surely Allah is with the patient"* (2/153),... *"And We will most certainly try you with somewhat of fear and hunger and loss of property and lives and fruits; but give glad tidings to those who patiently persevere, Who say, when afflicted with calamity: to Allah We belong, and to Him is our return"* (2/155-156).

The ethical rule *"No harm shall be inflicted or reciprocated in Islam"* (la zarar va la zirar) expounded by the Prophet Muhammad is evoked when matters concerning critical care are under consideration. This rule allows for important distinctions and rules about life-sustaining treatments in terminally ill patients; the distinctions on which ethical decisions are made include the difference between killing (active

euthanasia) and letting die (passive euthanasia).<sup>37</sup> Some Muslim scholars assume that Islamic law permits withdrawal of futile and disproportionate treatment on the basis of the consent of the immediate family members who act on the professional advice of the physician in charge of the case.<sup>37</sup>

### CONCLUSION

Because cancer patients are increasing worldwide, paying special attention to ethical issues is very essential. An emphasis on ethics has been also voiced by medical and religious professions in Iran in recent decade.<sup>38-40</sup> Because of Islamic background, ethics in Iran is a culturally adapted Islamic ethics. Eternity of life (Immortal Soul), association of a human being with God and universe, life after death, seeking perfection and eternal salvation, altruism, and benevolence to fellow human beings are some of the principles of Islamic ethics. Islam accepts the four basic principles of bioethics but suggests a different interpretation of them. Considering this issue, compiling specific culturally appropriate guidelines for patient's approach and also ethical review of researches in the field of oncology is a necessity. Practical guidelines<sup>41</sup> for end-of-life care for patients with cancer have been provided in some health-care systems. In this setting, there has been also increasing concern in attaining control of the physical, psychological, social, and spiritual distress of the patient and family. Communications deficiencies between patients and doctors cause anguish and create a situation for ethical conflicts and dilemmas. Medical schools must teach the mastery of listening and communicating.

Strengthening Ethics Committees in the hospitals and more strict supervision for patients' rights observance in the healthcare system are also necessary.

### REFERENCES

1. Surbone A, Ritossa C, Spagnolo AG. Evolution of truth-telling attitudes and practices in Italy. *Crit Rev Oncol Hematol* 2004; 52(3):165-72.
2. Maguire, P. Improving communication with cancer patients. *Eur J Cancer* 1999; 35(10):1415-22.
3. Steinhauser KE, Christakis NA, Clipp EC, McNeilly M, McIntyre L, Tulsky JA. Factors considered

- important at the end of life by patients, family, physicians, and other care providers. *JAMA* 2000; 284(19):2476-82.
4. Griffin JP, Nelson JE, Koch KA, Niell HB, Ackerman TF, Thompson M, et al. End-of-life care in patients with lung cancer. *Chest* 2003; 123(1 Suppl):312S-331S.
5. Anderlik MR, Pentz RD, Hess KR. Revisiting the truth telling debate: a study of disclosure practices at a major cancer center, *J Clin Ethics*. 2000 Fall;11(3):251-9.
6. Baile WF, Lenzi R, Parker PA, Buckman R, Cohen L. Oncologists' attitudes toward practices in giving bad news: an exploratory study. *J Clin Oncol* 2002; 20(8):2189-96.
7. Elger BS, Harding TW. Should cancer patients be informed about their diagnosis and prognosis? Future doctors and lawyers differ. *J Med Ethics* 2002; 28(4):258-65.
8. Seo M, Tamura K, Shijo H, Morioka E, Ikegame C, Hirasako K. Telling the diagnosis to cancer patients in Japan: attitude and perceptions of patients, physicians and nurses. *Palliat Med* 2000; 14(2):105-10.
9. Hyun I. Waiver of informed consent, cultural sensitivity, and the problem of unjust families and traditions. *Hastings Cent Rep* 2002; 32(5):14-22.
10. Surbone A. persisting differences in truth telling throughout the world. *Support Care Cancer* 2004; 12(3):143-6.
11. Faber-Langendoen K, Lanken PN. Dying patients in the intensive care unit: forgoing treatment, maintaining care. *Ann Intern Med*. 2000; 133(11):886-93.
12. Breslin JM, MacRae SK, Bell J, Singer PA. University of Toronto Joint Centre for Bioethics Clinical Ethics Group. Top 10 health care ethics challenges facing the public: views of Toronto bioethicists. *BMC Med Ethics* 2005;6:E5.
13. van der Heide A, Deliens L, Faisst K, Nilstun T, Norup M, Paci E, et al. End-of-life decision-making in six European countries: *Lancet* 2003; 362(9381):345-50.
14. World Health Organization. Symptom relief in terminal illness. Switzerland, Geneva: WHO, 1998.
15. Steinhauser KE, Clipp EC, McNeilly M, Christakis NA, McIntyre LM, Tulsky JA. In search of a good

## Cancer Ethics from the Islamic Point of View

- death: observations of patients, families, and providers. *Ann Intern Med* 2000; 132(10):825-32.
16. Singer PA, Martin DK, Kelner M. Quality end-of-life care: patients' perspectives. *JAMA* 1999; 281(2):163-8.
  17. Steinhauer KE, Christakis NA, Clipp EC, McNeilly M, McIntyre L, Tulsky JA. Factors considered important at the end of life by patients, family, physicians, and Other Care Providers. *JAMA* 2000; 284(19):2476-82.
  18. Cavalieri TA. Ethical issues at the end of life. *J Am Osteopath Assoc* 2001; 101(10): 616-622.
  19. Center for Bioethics, University of Minnesota. End of life care: an ethical overview. University of Minnesota, 2005. Available at: [http://www.bioethics.umn.edu/publications/bo/End\\_of\\_Life.pdf](http://www.bioethics.umn.edu/publications/bo/End_of_Life.pdf). Accessed April, 2006.
  20. Eslami Ardakani SH. Euthanasia from Christian and Islamic point of view. Proceedings of International Conference on "Attitudes towards Death in the Context of Social and Technological Changes: Challenges for Muslims and Christians", 8–10 April 2006. Center of Human Rights Peace and Democracy, Shahid Beheshti University, Tehran, Iran: 31-33.
  21. Somerville MA. Death talk": debating euthanasia and physician-assisted suicide in Australia. *Med J Aust* 2003; 178(4):171-4.
  22. The British Medical Association. Withholding and withdrawing life-prolonging medical treatment, 1999. Available at: <http://www.bma.org.uk/ap.nsf/Content/Endoflife>. Accessed April, 2006.
  23. American Medical Association. AMA Policy E-2.20 Withholding or Withdrawing Life Sustaining Treatment. Available at [www.ama-assn.org](http://www.ama-assn.org). Accessed April, 2006.
  24. Schapira DV, Studnicki J, Bradham DD, Wolff P, Jarrett A. Intensive care, survival, and expense of treating critically ill cancer patients. *JAMA* 1993; 269(6):783-6.
  25. Johnson RF, Baranowski-Birkmeier T, O'Donnell JB. Advance directives in the medical intensive care unit of a community teaching hospital. *Chest* 1995; 107(3):752-6.
  26. Teno JM, Lynn J, Phillips RS, Murphy D, Youngner SJ, Bellamy P, et al. Do formal advance directives affect resuscitation decisions and the use of resources for seriously ill patients? SUPPORT Investigators. Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments. *J Clin Ethics* 1994; 5(1):23-30.
  27. Vähäkangas K. Ethical aspects of molecular epidemiology of cancer. *Carcinogenesis* 2004; 25(4):465-71.
  28. American Society of Human Genetics. DNA banking and DNA analysis. Available at: [www.faseb.org/genetics](http://www.faseb.org/genetics). Accessed April, 2006.
  29. Council for International Organizations of Medical Sciences (CIOMS). International Ethical Guidelines for Biomedical Research Involving Human Subjects. Available at: [www.cioms.ch/guidelines](http://www.cioms.ch/guidelines). Accessed April, 2006.
  30. Human Genome Project: NCHGR-DOE Guidance on Human Subjects issues in Large-Scale DNA sequencing. Available at: [www.ornl.gov/TechResources/Human\\_Genome](http://www.ornl.gov/TechResources/Human_Genome). Accessed April, 2006.
  31. National Bioethics Advisory Commission (NBAC). Ethical and policy issues in research involving human participants. Available at: [www.bioethics.gov](http://www.bioethics.gov) Accessed April, 2006.
  32. United Nations Educational, Scientific and Cultural Organization (UNESCO). The Universal Declaration on the Human Genome and Human Rights—from theory to practice. Available at: [www.unesdoc.unesco.org](http://www.unesdoc.unesco.org). Accessed April, 2006.
  33. de Wert G. Ethics of predictive DNA-testing for hereditary breast and ovarian cancer. *Patient Educ Couns* 1998; 35(1):43-52.
  34. World Medical Association. WMA proposal on predictive medicine. *Bull Med Ethics* 1995; Nov. Issue: 5-6.
  35. Wolfberg AJ. Genes on the Web — Direct-to-Consumer Marketing of Genetic Testing. *N Engl J Med* 2006; 355(6):543-5.
  36. Najafi Afra M. Death: transcendence or imperfection. Proceedings of International Conference on "Attitudes towards Death in the Context of Social and Technological Changes: Challenges for Muslims and Christians", 8–10 April 2006. Center of Human Rights Peace and Democracy, Shahid Beheshti University, Tehran, Iran: 26.
  37. Sachedina A. End-of-life: the Islamic view. *Lancet*. 2005; 366(9487):774-9.
  38. Larijani B, Malek-Afzali H, Zahedi F, Motevaseli E. Strengthening Medical Ethics by Strategic Plan in

- Islamic Republic of Iran. *Developing World Bioeth* 2006; 6(2):106-10.
39. Larijani B, Zahedi F, Malek-Afzali H. Medical ethics in the Islamic Republic of Iran. *East Mediterr Health J* 2005; 11(5-6):1061-72.
40. Larijani B, Zahedi F. Health Promotion, Islamic Ethics and Law in Iran. *Daru* 2006; (Suppl 1):7-9.
41. Holland JC, Chertkov L. Clinical practice guidelines for the management of psychosocial and physical symptoms of cancer: improving palliative care for cancer: summary and recommendations. Washington: National Academy Press, 2001; 199-232.

en. dc.subject. Islamic Ethics. en. dc.subject.Â Medical genetic ethics, Islamic views and considerations in Iran ĩ» ħ. Zahedi, Farzaneh; Larijani, Bagher (2006-01). Related Items in Google Scholar. Then the Islamic views will be stated considering two cases. This review intends to provide health care professionals a basic knowledge about the main issues in cancer ethics in order to facilitate their decision-making in clinical practice. Do you want to read the rest of this article? Request full-text. Citations (13). References (5). There is delicate interplay between autonomy and beneficence which made some differences in truth telling between the cultures, from the in medicine [1]. In the case of a cancer patient, physicians sometimes must decide whether the patient should be informe Euthanasia: An Islamic Ethical Perspective Islamic jurisprudence, based on a convincing interpretation of the holy Koran, does. not recognize a personâ€™s right to die voluntarily. The Islamic arguments against euthanasia can be summarized in two main reasons: 1-Life is sacred and euthanasia and suicide are not included among the reasons allowed for killing in Islam.Â Besides cancer there can be many different reasons for which one might commit suicide. This story illustrates the kind of conceptual inaccuracy that can be in play. The forester was not suffering extreme pain, and he could possibly have been cured.Â only from the semantic point of view. References: The Holy Koran Mondelli, F.; Levi, D.; Magistrelli, S.; Prato Previde, E. & Valsecchi, P. (2002).