CHAPTER 10

An Islamic Bioethical Framework for Withholding and Withdrawing Life-Sustaining Treatment

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Introduction

Many Muslim clinicians, patients and families look to ethical guidelines on end-of-life decisions sourced within their faith tradition when dealing with withholding and withdrawing life-sustaining treatment (Padela and Mohiuddin 2015). Ethical guidance is sought from Muslim jurisconsults (muftīs), who provide authoritative, non-binding expert legal opinions (fatāwa) to queries, having analysed past and present juridical rulings from scriptural-based sources.1 Fatwās offered by Muslim jurisconsults related to important bioethical issues at end-of-life care, provide specific legal responses to bioethical cases. It has been argued that sometimes these fatwās are vague, have gaps, are scattered, difficult to interpret, and lack a practical focus neglecting healthcare policy implication. As a result, practical difficulties arise when such fatwās are used to determine the course of action in end-of-life care to specific cases (Padela, Shanawani and Arozullah 2011; Mohiuddin et al. 2020) It is no wonder that many Muslims around the world still request futile treatment for dying family members, and the shift of focus to palliative care is taken inappropriately late in the course of patients’ illness (Mobeireek et al. 2008; Yazigi et al. 2005) This causes unnecessary distress for patients and families and leads to conflict between families and caring physicians. Therefore, it is important that we seek more clarity around the practical implications of the justification criteria mentioned in the fatwās for withholding and withdrawing life-sustaining treatments (LST), highlighting where there is a need to revise current Islamic guidelines.

Life-sustaining treatment is any treatment that serves to prolong life without reversing the underlying medical condition. It may include, but is not limited

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1 Fatwā plural fatāwā is an authoritative, but non-binding legal opinion or interpretation on a point of Islamic law given by a qualified legal scholar (known as a muftī) or collectively, comprising a number of Muslim scholars with an interdisciplinary team of biomedical scientists. A fatwā is usually issued in response to questions from individuals or Islamic courts.
to, cardiopulmonary resuscitation (CPR), mechanical ventilation, renal dialysis, chemotherapy and artificial nutrition and hydration (ANH). Withholding LST is the decision not to make further life-sustaining therapeutic interventions while withdrawing LST is the removal of a LST which has been started in an attempt to sustain life.

An analysis of the fatwā literature related to justification criteria for foregoing LST shows that most contemporary Muslim jurists deem it permissible to withhold and withdraw LST in the following situations (Mohiuddin et al. 2020).

1. *Futility* of continued therapy,
2. Diminished neurological state of the patient and,
3. Compounding harms from continued clinical care.

The language and terms used to describe states justifying foregoing treatment, such as “futility,” “terminal illness,” “depressed neurological state” and “compounding burden/harm,” are nuanced and vague, leading to difficulties in interpretation and lack a practical focus, especially because specific clinical examples are mostly avoided in the fatwās (Mohiuddin et al. 2020). It is also not clear whether Islam identifies a moral distinction between withholding and withdrawing LST.² For example, is a decision not to start mechanical ventilation on a seriously breathless patient, morally distinct to a decision to switch off a ventilator from the same patient after having initiated treatment? Despite wide agreement by Western ethicists that there is no ethical difference between withholding and withdrawing LST, these issues continue to generate considerable debate (Vincent 2005; Weinstein and Fineberg 1980).

The fatwās are not explicit about any major distinction between withholding or withdrawing treatment, yet majority of Muslim jurists tend to add more stringent conditions and prohibitions to withdrawing LST compared to withholding LST. These stringent conditions and prohibitions of withdrawing LST are also scattered and diverse. Most fatwās mention that LST can be withdrawn if treatment is *futile* (IIFA 1986, 523) Some generally prohibit the withdrawal of LST and only permit in extreme situations when the patient is brain dead. Others prohibit even when the patient is brain dead, because to them brain death is not “actual” death (al-Jabūrī 2015; Jāb Allāh 2015).

Furthermore, Muslim jurists differentiate between two categories of LST; life-support like CPR and mechanical ventilation, and ancillary interventions like ANH, pain control and antibiotics. They claim that ANH in particular must be maintained as a necessary part of overall care in contrast to CPR and

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² There appears to be little deliberate distinction made between withdrawal and withholding of treatment (see Mohiuddin et al. 2020).
mechanical ventilation (al-Bār 2015; Jāb Allāh 2015; al-Jibrīn 2015, al-Khādīmī 2015). It is not clear why such a distinction exists and in what context.

In this chapter, I propose that the nuanced understanding of “futility,” that justifies foregoing LST, is best avoided and an alternative approach within the perspective of an Islamic ethico-legal framework be used for withholding and withdrawing LST, framed around “religious duties and obligations” for clinicians, patients and surrogate decision makers. I argue that there is no moral distinction between actions of omission and commission when withholding and withdrawing LST. Any distinction claimed between them is not because of acting or not acting, but because of our duty and obligation to rescue patients, which depend on patient prognostic outcomes, and the balance of benefits versus compounding harms of treatment, and the underlying patient condition.

The distinction between the two categories of LST; life-support and ANH, exists because of our duties and obligations to treat patients related to outcome of certainty of saving life. ANH is certain to sustain life and thus obligatory, whereas this is not always the case with life-support like CPR and mechanical ventilation.

I propose that the balance of benefit versus compounding harms from continued care ought to be assessed using quantitative and qualitative evaluations of life. This serves the best interests of patients by assessing whether treatment will prolong the person’s life significantly, alleviate burdens of illness and provide a worthwhile quality of life or meaningful life. The types of harm, the degrees of harm, and the kind of assessment of harm we ought to make, that extends to other considerations of a non-physical nature, like bodily dignity and loss of benefit to afterlife, will all be discussed.

By exploring these concerns using specific clinical situations of withholding and withdrawing LST, it is expected that readers will be better informed about how an Islamic bioethical framework is best implemented practically.

2 From “Futility” to “Duties and Obligations”

There is not enough guidance to inform clinicians, patients and families about what is understood by medical futility in the fatwās. Muslim scholars justify withholding and withdrawing LST in patients when treatment is seen futile, because the state of the patient is unsuitable, the condition incurable and unresponsive to treatment, or there is inevitable death.3 The problem

3 For example, the Saudi Permanent Committee for Islamic Research and Fatwā issued a statement stating: If the patient’s state is unsuitable or non-beneficial (ghayr ṣāliḥa) for
is that these descriptions are unclear and do not provide enough guidance for Muslims to apply to policy⁴ (Mohiuddin 2020). For example, there is little clarity in these fatwās about what Islam would consider an unsuitable state, justifying foregoing LST. Rather, many of these fatwās mention the physician as the one who determines unsuitability and therefore decides on the permissibility of foregoing LST.

Relying solely on the physician’s judgement is problematic. Expert physicians are trained to provide scientific opinions and judgements regarding suitability of treatment, which presuppose moral judgements and often standards of quality of life. Decisions about best interests of a patient involve moral judgements, like what is of value in life, how best to promote the patient’s interests, and how different or competing interests should be weighed against each other. Different healthcare professionals and different families may reach different answers about what would be in the best interests of the patient, because they have a different understanding about the relevant facts. They may also disagree because they have different values. Such decisions are influenced and depend on societal values, culture and faith, and are not just scientific judgements. Societal values related to standards of quality of life can change with changing politico-social trends over time.⁵ Therefore, reliance on expertise of physicians does not always provide an adequate account of what is futile, because futility should also be a moral judgement by Islamic standards.

Moreover, futility descriptions are not clear. Controversy exists about what constitutes futility or futile intervention (Helft, Siegler and Lantos 2000, resuscitation, as agreed by three competent specialised physicians, then there is also no need for any resuscitative measures (second statement).

This is further explained in another one of their statements: If the patient’s illness is incurable and unresponsive to treatment (mustaʿṣiyan ghayra qābil al-ʿilāj) and death is inevitable through the witness of three competent specialised physicians then there is also no need for any resuscitative measures (third statement) (al-Lajna al-Dāʾima 1989).

The Saudi Permanent Committee for Islamic Research and Fatwās (al-Lajna al-Dāʾima lil-Buḥūth wa-l-Iftāʾ) is a committee established by royal decree in 1971 by King Faysal b. ‘Abd al-ʿAzīz (d. 1975) of Saudi Arabia. It issues fatwās relevant to all aspects of life (regarding creed, worship, and social issues) both in print and online. Its members are drawn from the most senior Sunni scholars of fiqh in Saudi Arabia. Its head is the Grand Mufti of Saudi Arabia (www.fatwa-online.com/permanent-committee/).

4 The issue of defining “futility” is not just a problem for Muslims but also heavily criticised as being vague in western medical ethics also (see Schneiderman et al. 1990).

5 The proportion of deaths in patients with a decision to withhold/withdraw life-sustaining treatment ranged from 10% in South Asia to 67% in Oceania. Decisions to withhold/withdraw life-sustaining treatment were less frequent in low/lower-middle GNI countries than in high GNI countries (6% vs 14%; P < .001) (see Lobo et al. 2017; Prendergast and Luce 1997).
Futility is described as (Baruch and Halevy 1995; Kopelman 1995; Miles 1994; Youngner 1988):

i. what cannot be performed
ii. what is highly unlikely to be efficient (statistically the likeliness of success is extremely small)
iii. what can only produce low grade insignificant outcome (qualitative results are poor)
iv. what is more burdensome than beneficial
v. what is completely speculative
vi. what is of predicted improbable outcome, success
vii. what is an unacceptable benefit-burden ratio.

In other words, futility can mean many things related to the physiological state of the patient, and is best avoided, requiring us to use more precise language (Wilkinson and Savulescu 2011). An Islamic ethico-legal framework for withholding and withdrawing LST ought to be framed around duties or religious obligations for clinicians, patients and surrogates. These obligations ought to be determined using both scientific and values judgements.

An accurate prognostic outcome measure of the effectiveness of life-saving medical intervention provides decision-makers valuable information about the limitations of treatment choices and their level of benefit. This is a scientific judgement and provides information about, “what we can do.” If we know that life support is likely to be 60% effective in a patient whose neurological outcome will be normal, then treatment in such a patient is beneficial. If the patient’s treatment is likely to be less than 1% effective with a serious permanently diminished neurological state, then treatment may be described as ineffective or futile and the underlying condition incurable and unresponsive. Scientific judgements therefore provide information about what we can achieve with available treatment options.

Scientific judgements thus assess whether there is any realistic chance of patient’s condition improving if life-support is initiated or is continued, and so, inform us of our options and their statistical outcomes. This is expected to be objective, depends on the expertise and accuracy of diagnosis and prognosis. The reliability of technology and clinical testing used, as well as the expert’s ability to interpret the results, are essential to attain an accurate account of the outcome. Scientific judgement is important because it informs us of where we are and what we can achieve. However, it should not be considered the sole consideration when justifying foregoing LST.

Value judgements are evaluations of the balance of competing harms and benefits, from the perspective of physician’s standards or priorities, when
considering the right course of action related to, “what we ought to do.” Value judgements assess what we ought to do if the patient’s condition does not improve. Should active treatment be initiated, should LST continue, or should it stop, particularly if surrogates do not give permission to withdraw treatment? These are ethical questions, not scientific ones. There are varied views globally about what to do, and they differ amongst different societal cultures, people and faiths. Some favour that resuscitative measures and life-support ought to continue indefinitely for patients who are in this situation, even if there is no chance of improvement. Whereas others may feel that to continue is the wrong thing to do – treatment may prolong life but may be doing more harm than good.

Both scientific judgements and value judgements combined, offer a practical approach to decide whether foregoing LST treatment is justified or not. The decision to use a procedure is based on the product of the probability of success and the quality (utility) of the outcome in terms of quality of life (Weinstein and Fineberg 1980). These factors determine whether it is considered right or wrong to treat, and our obligations to treat. Justifications for foregoing treatment based on definitions or descriptions of futility are not helpful, rather what needs to be determined is whether it is a duty or an obligation, optional or wrong to withhold or withdraw LST, having combined both scientific and value judgements.

So what are obligatory treatments, optional treatments and treatments which should be withheld or withdrawn? The Islamic bioethical legal framework views acts generally on the basis of whether they are obligatory (wājib), permissible (mubāḥ) or optional, and prohibited (ḥarām). Therefore, treatments can be obligatory, optional, or it can be wrong to treat, based on scientific and value judgements. Treatments can be “obligatory to treat” when it is considered wrong not to treat, like when we are able to significantly extend someone’s life by initiating life-sustaining measures. It can be wrong if we fail in our duty to attempt to do this and we will be culpable and sinful. It can be wrong to treat when it is considered, “obligatory not to treat,” because it seriously violates patient and public interests. Like when it causes severe pain, violates human bodily dignity, when the burden of treatment outweighs the anticipated benefit of brief prolongation of life, or when there are limited resources depriving other sick patients of LST who are in greater need. If we fail in our duty to withdraw treatment, we will be culpable and sinful.

Treatments may be optional to treat when it is neither obligatory nor prohibited, in other words, there is no sin. Usually, such treatments are recommended by physician and can be authorised or refused by a patient or
surrogate. Even though treatments may not be obligatory, the ethics of our duty to patients, demands that care is optimised in line with patient wishes or those of surrogates.

If an Islamic ethico-legal framework for withholding and withdrawing LST ought to be framed around “duties” or “religious obligations,” then these obligations will remain equally coherent and consistent in both acts of omission and commission; in other words, there is no moral distinction between obligations related to withholding and withdrawing LST.

3 The Withdrawing and Withholding Distinction

Most bioethicists do not draw a distinction between withholding and withdrawing LST. Moral obligations to help, prevent or remove harm are seen morally equal for both. Moral weight is based on the outcome of withholding or withdrawing treatment, and so withholding and withdrawing treatment is morally equivalent because of the same effect it causes (Sanchini et al. 2014) For example, if a patient is unable to breathe spontaneously, the “active” decision to stop mechanical ventilation will have the same immediate effect, consequence and outcome as the “passive” decision not to initiate mechanical ventilation. The outcome of the underlying disease or illness of the patient will be the same, i.e., death, because the patient cannot breathe spontaneously, and breathing will not be supported if the ventilator is withdrawn (Vincent 2005) In each case, we decide which treatment is to be applied in the immediate future, to withhold or withdraw, and the immediate result will be the same regardless of the decision (Melltorp 1997).

Even though most guidelines emphasise that there is no ethical difference between withholding and withdrawing LST (GMC 2010a),6 most health professionals in ICU are of the opinion that there is an ethical difference. Attempts justifying an inherent distinction between withholding and withdrawing seem to be controversial and it is even argued that such a distinction should be considered by recommending a change in emphasis in the professional guidelines (Melltorp 1997). It might be argued that withdrawing LST by the physician interrupts the treatment and this is the direct cause of the patient’s death, whereas withholding LST by a physician does nothing to causally contribute to it, rather the illness takes its natural course. Or it may be argued that the moral

6 In the UK withholding and withdrawing treatment are also regarded as legally equivalent. Bolam v Friern HMC [1957] 2 All ER 118.
difference does not exist in the action and omission as such, but it is the conditions in which action and omission take place (Sanchini et al. 2014).

In my opinion, there is no intrinsic moral distinction between withholding and withdrawing LST. If a moral distinction is felt then this is not because of the distinction between acting and not acting that makes us feel this way, rather it is in the conditions in which actions and omissions take place. If treatment is not obligatory and the patient chooses not to start LST, then it is permissible to withhold. If the treatment is started, but the treatment does not succeed in improving the condition, and the odds of effectiveness remain the same, then the non-obligation will remain and the treatment can be withdrawn. If the odds change whilst patient is receiving LST, and it is now very effective due to a very good response from the patient, then it will be an obligation to continue treatment if it is lifesaving. The moral distinction therefore relates to the obligations related to the certainty of effectiveness of treatment as a condition, and not merely actions of omission and commission related to withholding and withdrawing LST. Similarly, if compounding harms due to continued LST significantly outweigh benefits of treatment then these are additional conditions which differentiate withholding and withdrawing LST in certain situations. A thorough evaluation of obligatory treatments in Islam is required, comparing situations and conditions of withholding LST with that of withdrawing LST to support this argument. I will relate the obligations related to certainty of effectiveness of treatment as a condition, and compounding harms due to continued LST.

4 Obligations Related to Withholding LST

In order to know our obligations related to withholding LST, it is important to know what our ethico-legal position or duty is when seeking treatment in Islam generally. Are treatments generally obligatory in Islam, and if not, at what stage do they become obligatory, optional or even prohibited? In Islam, medical treatment is encouraged and is promoted as an established practice of the Prophet and is not something which is contrary to trust in God’s decree (tawakkul). Treatment is therefore seen optional, and generally not an obligation according to all four Sunnī schools of jurisprudence. This is evident from the

7 Sunnī Islam is separated into four main schools of jurisprudence, namely, Ḥanafi, Mālikī, Shāfi’ī, Ḥanbalī. These schools are named after Abū Ḥanīfah (d. 150/767), Mālik b. Anas (d. 179/796), al-Shāfi’ī (d. 204/820), and Ahmad b. Ḥanbal (d. 241/855), respectively. They emerged in the third/ninth and fourth/tenth centuries and by the sixth/twelfth century

Consuming food and drink are natural and essential acts and necessities of life and do not fall under the category of taking medicine or treatment. However, Islamic legal texts do refer to consumption of food and drink alongside discussions on obligatory treatments, because they are seen as acts which are obligatory to sustain life and hence are comparable to treatments in this sense. Framed in this sense, Muslim jurists consider the consumption of food and drink an obligation because it prevents death from starvation. This obligation is realised through two indications, both of which relate to certainty of outcome. The first certainty of outcome is the “certainty of death occurring if we abstain” from food and drink – because death is certain to follow from the state of starvation. The second certainty of outcome is the “certainty of success and effectiveness of using the means” to overcome death. Food and drink are certain (mutayaqqan) to save life when a person is at risk of death from starvation and thirst. If you are at a high risk of death due to starvation and you refuse to eat and drink, you will die as a consequence. Because food sustains life, to then abstain from food with the intention of death will be an act of sin. This is because of the verse of the Qurʾān: “Let not your own hands contribute to your destruction...” (Q 2:195) Therefore, it is obligatory for you to consume food and drink to save yourself from starvation.

Muslim jurists mention that when a doctor recommends you take medical treatment and you refuse, and as an outcome you die, you will not be sinful. The reason being that your underlying condition is not certain to be life-threatening, like the seriousness of state of starvation, and the medical treatment offered is not certain to save your life, like the certainty of food and drink, and hence the treatment is not an obligation and the patient is not culpable (Nizām al-Dīn et al. 2000, 5:355, 360; al-Zayla’ī 2000, 6:33; Abū l-Ma‘āli

almost all jurists aligned themselves with a particular madhhab. These four schools recognise each other’s validity and they have interacted in legal debate over the centuries. Rulings of these schools are followed across the Muslim world without exclusive regional restrictions.

8 For a more detailed account in English of the differences amongst the different Sunnī schools see Padela and Qureshi 2016.
Treatments, however, can be obligatory in certain situations. An example is given in the *fiqh* literature of a person who has severe continual bleeding from a venesection site (*faṣd*) or wound, and there is certainty of death if not treated. The effectiveness of using a tourniquet (i.e., compressing a limb with a cord or tight bandage) to prevent bleeding to death is certain to be effective. In such a situation it becomes obligatory (*wājib*) for the patient to wear a tourniquet otherwise he will bleed to death. If there was little risk of death or the tourniquet was not considered to be very effective, then it would not be an obligation, rather it would be optional due to lack of certainty of death and/or the patient’s life being saved. Drinking and eating to prevent death from starvation is obligatory because there is certainty of preventing death. This was not seen to be the case for medical treatment historically, because medicine was not certain in its effectiveness then as is mentioned in the books of *fiqh*. Examples given are cupping (*ḥijāma*), taking honey or humoral treatment, all of which at best have some benefit, but not as lifesaving treatments. Hence, they were not considered obligatory. With current advances in technology, we are able to save lives with certainty, using life support measures like mechanical ventilators.

Medical treatment is therefore obligatory, if (1) there is a certainty of risk of death if no treatment is taken, and (2) the lifesaving treatment offered is certain to save life. Withholding LST in such patients is prohibited and sinful. However, if life cannot be saved at this level of certainty, then LST is not an obligation, but recommended or optional.

Classical Muslim scholars assert that judgements around certainty of treatment outcomes should be based on good empirical evidence (*mutayaqqan bih bi-ʿtibār al-ʿāda*) (al-Zaylaʿī 2000, 6:33). If scientific judgements can accurately predict the prognostic outcome of the treatment, using previously established clinical data related to effectiveness of treatment for similar cases, then this will satisfy what is required to determine whether a treatment is obligatory. Therefore, having knowledge of the prognostic outcome of an underlying condition if treatment is not sought, as well as having the knowledge of the effectiveness of treatment offered, are both essential scientific or clinical judgements which determine whether treatments are obligatory or not.

Muslim scholars describe different degrees of certainty of treatment effectiveness which impart normative obligations (al-ʿAynī 2007, 471; al-Haythami 2016, 3:182; Abū Ghudda 1998, 173). The different degrees of certainty of treatment effectiveness are described as being (1) uncertain (*shakk*), which refers
to a treatment outcome where success and failure are equally probable (istiwāʾ tarafay al-shayʿ). This can be taken broadly as being approximately 50% effective (2) Presumption (ẓann) refers to a treatment outcome which is more likely, but treatment failure is significant enough that it cannot be easily dismissed. In other words, failure is possible, but less likely. This can be taken as being between, above half (50%), and below dominant probability, where (3) dominant probability (ghalabat al-ẓann), is a dominant successful outcome because treatment failure is predicted to be very unlikely. This can be taken to be approximately above 75% in its effectiveness, as even though the remaining outcome can be dismissed on the basis that it is very unlikely, it cannot be excluded entirely. Dominant probability is at times seen epistemically no different to (4) certainty (yaqīn), where certainty is very nearly 100%. Dominant probability achieves a confidence level similar to certainty as a legal proof, even though certainty refers to an outcome that does not entertain any doubt (wahm), appreciating that certainty in medical treatment can never be absolute at 100% (al-Ḥamawi 1985, 1:193; Ḥaydar n.d., 1:35–6; al-Nawawi 2008, 5:270). When we turn to Islamic legal authority we can see that the tradition at times uses the term “yaqīn” (certainty) when referring to legal issues, yet we know that, in reality, we are unable to achieve this level of certainty, rather recourse is to ījtihād, which leads to speculative (ẓannī) claims. Therefore, the threshold at which treatment becomes obligatory is at level of dominant probability (ghalabat al-ẓann) and not strictly at level of certainty (yaqīn), as realistically one cannot entirely exclude the remote possibility that the person may not survive, yet one is quite sure that they will – like when a starving person is given food and drink, he may still die, though very unlikely. Throughout the remaining chapter, any reference to “certainty” of treatment effectiveness will be understood at the epistemic level of dominant probability.

According to all four Sunnī schools, these grades of certainty, related to effectiveness of treatment, are to be determined through expertise and are to be evidence based (tajriba) (Ibn al-Humām 2003, 4:378; Mullā Khusraw 2010, 2:491; Ibn Nujaym 1997, 6:229; Ibn ʿAbīdin 1994, 2:117; al-Ḥaṣkāfī 1998, 1:76; Ṭahṭāwī 1997, 1:430; al-Dasūqī n.d., 2:170). Treatment should be based on the most up-to-date clinical evidence and/or appropriate guidelines insofar as these exist. We can therefore determine whether a particular LST is obligatory, based on certainty of outcomes. If LST is not obligatory, then patients who have the capacity to make their own decisions have the right to refuse treatments (including those intended to sustain life), if they are not deemed obligatory, even if physicians regard such treatments in the patients’ best interests.

Consequently, what are our obligations when it comes to withholding LST in patients in need of CPR, mechanical ventilation and ancillary interventions
Like ANH, pain control and antibiotics? Is CPR obligatory and are, “do not resuscitate” (DNR) orders, permissible? The purpose of CPR is to attempt to restart the heart or breathing and restore circulation after a cardio-respiratory arrest. It often includes invasive procedures, for example, obtaining access to the patient’s airway and circulation. Its success rate is dependent on circumstance but generally lower than is commonly perceived by the general public. The chance of survival to hospital discharge for in-hospital CPR in older people is low to moderate (11.6–18.7%) and decreases with age (van Gijn et al. 2014). Survival of children and those 18 to 69 years is no more than 45.4% (Zoch et al. 2000; Alsoufi et al. 2007; Danciu et al. 2004). In other words, most patients after CPR do not survive. Therefore, CPR does not qualify as obligatory treatment and is optional. Even though the patient will die if not treated, CPR cannot rescue the patient with certainty, and therefore will not be an obligatory intervention, rather it will be optional. Decisions are therefore left to patients, through advanced directives, or patient’s families or other surrogate decision makers about DNR orders. If the patient understands the nature and consequences of his or her decision, is assessed as having capacity to make the decision and is supported by their family, the provision of further LST may no longer be ethically justifiable even if it has the potential to provide some limited clinical benefit.

Similarly, most cases of patients who end up on ventilators have poor prognosis of survival, and majority of the time this treatment is not obligatory as it does not achieve certainty in its effectiveness (Knaus 1989; Esteban et al. 2002). However, each case is to be judged based on pre-illness quality of life to conclude significance of prognosis for long-term survival, combined with additional information about patient's wishes.

Ancillary interventions like pain control and antibiotics will only be obligatory if by withholding them there is certainty that the patient will die. For example, an elderly patient is at risk of death from septicaemia because of non-treatment of urine infection, but the risk of death is not certain, and hence antibiotics are not obligatory treatment (Gharbi et al., 2019) Similarly a patient is very unlikely to die from severe pain even though his quality of life may be severely diminished. Death will be because of the underlying condition. Even though patients may experience severe pain, pain relief will not save life at level of certainty, and therefore it will not be obligatory. In fact, there are concerns about the possibility of certain pain medication hastening death in end-of-life care (Laserna et al. 2020).

Nutrition and hydration are obligatory because it is certain that withholding them will lead to death. However, when there are risks associated with giving food and drink, either by mouth or artificial nutrition and hydration, then
things can be more complex, because nutrition and hydration can potentially cause more harm, especially if administered through unconventional or artificial routes. All patients have a basic need for food and drink to maintain adequate levels of nutrition and hydration and to prevent the adverse outcomes associated with malnutrition or dehydration. This applies equally to those with life-limiting illness. Giving food by mouth is part of basic care and should be provided for those who can tolerate it without serious risk – for example, choking, aspiration, and who appear hungry and thirsty. A separate assessment of a patient’s fluid and nutrition needs should take place alongside assessment of their clinical condition and form a basic part of care. It will determine whether clinically assisted provision of nutrition and hydration is required. ANH is appropriate in many patients, including those with severe impairment or terminal illnesses. This may be through a naso-gastric tube, intravenous infusion, subcutaneous fluids, naso-jejunal tube or by percutaneous endoscopic gastrostomy (PEG) tube and central line etc. Some of these interventions can be invasive and intrusive, leading to hardship, burden and compromise patient dignity. It is therefore not obligatory to continue ANH if the patient is end-of-life, in their last few days of life, or there is evidence that ANH is not effective and unable to bring benefit to the patient, and the harm of intervention outweighs any benefit.

Regarding the prohibition of withholding nutrition and hydration in patients, to contextualise the fiqh literature further, this referred to individuals who had the capacity to eat and drink by mouth, unaided or through the help of others. It would have required them to be at least in a state of consciousness, so that they did not aspirate, and hence were in a state to benefit. Withholding food and drink is certain to lead to death if the underlying condition had not taken its toll already. With technological advances we are now able to provide nutrition and hydration to those who are at end-stage of disease, unconscious in their last few days, and are unlikely to benefit from nutrition and hydration. To withhold or withdraw ANH will not cause suffering or be harmful, nor will it be the cause, or contributor to death, but the cause of death will be the underlying illness.

Because nutrition and hydration is essential to sustain life, if evidence suggests with dominant probability that it is of no benefit or even harmful, then it will be permissible to withhold ANH, as then an established certainty (i.e., benefit of ANH) is proven not to be the case in a specific situation. Therefore, the obligations approach to the two categories of LST; life-support and ANH, differ on the basis of certainty of outcome, where ANH is established to be certain in sustaining life, and therefore requires strong proof to the contrary that it is certain that it is of no benefit to the patient in a specific situation for it not
to be obligatory. In other words, proof is required that there is certainty that ANH will not benefit the patient to justify withholding or withdrawal. This is not the case with life-support like CPR and mechanical ventilation, where they are not certain to sustain life, and require proof that they are certain to save life in specific situations to be obligatory.

ANH was originally developed to provide short-term support for patients who were acutely ill. For patients near the end-of-life, ANH is unlikely to prolong life, and can potentially lead to medical complications and increase suffering (Bruera et al. 2013; Casarett et al. 2005; Koretz 2007; Koretz et al. 2007). In such patients ANH will not be seen as obligatory treatment and may even be prohibited if the harms of ANH far outweigh the benefits.

In conclusion, treatments are therefore obligatory if there is certainty of loss of life due to the underlying condition and the treatment or intervention offered will save life with certainty. However, if the patient cannot be rescued with certainty, then there is no obligation to start treatment, rather it is recommended or optional. ANH can be withheld if there is certainty that it is of no benefit, that it will not cause suffering or that its harms far outweigh its benefits, whereas other LSTs can be withheld if there is no certainty of their benefit.

5 Obligations Related to Withdrawing LST

When deciding to withdraw treatment, it is important to know whether it is obligatory to continue LST, because then we are culpable and sinful if we withdraw obligatory treatment. If LST is not obligatory, to withdraw treatment is optional. It can even be prohibited and sinful if we do not withdraw, knowing that the harms due to treatment significantly outweigh the benefits.

It has already been explained that treatment is only obligatory when the condition of the patient is life-threatening and the treatment offered is certain to save life. If these conditions are not met, then it no longer remains obligatory. The same principle applies to withdrawing LST as there is no moral distinction between the two. A patient has an underlying respiratory condition and his breathing has deteriorated significantly. If he is not treated, there will be imminent death. If the use of a mechanical ventilator is certain to save his life, then it becomes obligatory to commence the patient on the ventilator. It remains obligatory to continue ventilation if the odds remain the same, i.e., effectiveness of outcome is certain. If he refuses and dies, he will be sinful. If death is not imminent, or LST is commenced but with no certainty of saving life, then to withdraw treatment will not be sinful, as it is not obligatory to continue. There is no certainty that he will die if LST is removed and there is
no certainty that it will rescue him if it is continued. If he dies, then there is no sin, as it was not an obligation to initiate the LST due to its uncertainty. The books of fiqh mention that if a doctor recommends treatment and the patient refuses and dies, he will not be sinful because the treatment is not certain to save his life (Nizām al-Dīn et al. 2000, 5:355, 360; al-Zaylaʿi 2000, 6:33; Abū l-Maʿālī 2004, 5:373).

In the situation where effectiveness of LST is not certain and is bordering around 50%, it is good medical practice for all attempts to be made in continuing optimal treatment, as there is reasonable chance of survival. It may also be a medico-legal duty for physicians to maintain LST with such odds of survival ensuring all reasonable approaches are taken to rescue the patient. However, it is incorrect to claim that continuing treatment in such patients is religiously obligatory and that the withdrawal of such treatment is prohibited and sinful, contrary to common belief.

Even when an illness has a reasonable prognosis, is reversible, is not terminal and treatment is not futile, such patients can decide to withhold or withdraw LST against physician advice. They will not be religiously culpable or sinful unless there is certainty that they will die if LST is stopped or withdrawn. It is only with certainty of effectiveness of treatment that continuing treatment remains obligatory for them.

On a practical note, certainty about treatment outcome is rarely possible when making any clinical decision. A relatively high degree of confidence (ḥalabat al-ẓann) regarding outcomes is required to determine the gravity of the consequences of decisions to limit LST. In acute, emergency situations it is usually necessary to give LST first and to review the decision to continue when more information or expertise is available – like a more experienced and senior clinical opinion, important test results or more time to determine the level of improvement of the clinical state with continuing treatment. In less acute situations it can also be possible to attain higher levels of certainty by continuing to provide LST whilst waiting for more information to be assembled.

When patients in need explicitly refuse life-sustaining emergency treatment that is uncertain, the physician must choose between the undesirable options of foregoing beneficial treatment, and forcing treatment on a competent but unwilling patient, both of which have potential ethical and legal consequences. If treatment is not obligatory, informed consent and informed refusal allow competent patients to choose among treatments in accordance with their values, goals, and priorities for their future. When patients refuse recommended life-sustaining medical treatment, the duty rests with the physician to discern whether the patient has the decision-making capacity to reject
treatment. Patients, who have the capacity to make their own decisions, have the right to refuse LST and to have that refusal respected.

Many health care providers believe that any omission of a life-sustaining treatment is tantamount to passive euthanasia or at least assistance in the patient's suicide (Betzold 1992). It may also be the case that the patient is refusing the treatment in an attempt to end his life. Passive euthanasia is, “the intentional ending of one person's life by another, motivated solely by the best interest of the person who dies, through the deliberate [withholding or withdrawing] of a life-preserving substance or procedure.”9 The patient's death cannot simply be an accident, or even an undesired but a tolerated side effect for it to qualify as passive euthanasia. Both in physician assisted suicide PAS and euthanasia, the patient's death is intended, and the interventions are specifically chosen to bring about that outcome. As for the patient, if the patient is refusing treatment in an attempt to end his life, then this will be sinful for the patient. God states in the Qurʾān: “Do not kill yourselves, for God is merciful to you” (Q 4:29), and, “do not put yourself into destruction by your own hands” (Q 2:195). A willingness on the part of caregivers to forego LST does not logically equate a willingness to bring about the patient's death. The foregoing of LST reflects an acceptance of one's limited powers in rescuing the patient. Willingness to bring about the patient's death is the belief that an enacted death is morally preferable to a natural death. Withholding and withdrawing mechanical ventilation is motivated by the health care team's respect of the patient's autonomous decision and is not aimed at bringing about the patient's death (Brassington 2020). But even if the refusal is suicidal, that does not mean the health care team is assisting the patient in his suicide. The team simply has no ethical mandate to start or continue the life-sustaining treatment when a competent patient refuses treatment with uncertain outcome and the treatment is not religiously obligated. Team members should inform the patient, counsel him, negotiate, and use any other respectful means to get the patient to at least try a life-sustaining treatment that is likely to be effective and unlikely to cause severe side-effects. But if a competent patient persists in his refusal, the health care team no longer has a choice in the matter, must abstain from the refused treatment, and cannot be responsible either for the patient's subsequent death (Brassington 2020).

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9 For a cogent detailed explanation of definition of passive euthanasia see Brassington 2020. My emphasis added in brackets where author explains that this would refer to both withholding and withdrawing LST.
When treatment is certain to save life, but the burdens of life sustaining treatment significantly outweigh any benefits, in other words the adverse harms of intervention, i.e., hastening death or worsening the severity of other illnesses, outweighs any benefit, then it will be morally wrong and sinful to continue treatment. For example, if removal of a brain tumour is certain to save the life of a child and to prevent death, then this surgery is obligatory. But if the harms of the intervention, i.e., performing brain surgery using general anaesthetic will certainly hasten death or worsen illness, because the child has a serious congenital heart condition and will not tolerate the anaesthetic, then it will be prohibited to continue such intervention.

When treatment is certain to save life and the harm of intervention is equal to its benefit, then it will still remain obligatory to continue. Like when providing artificial nutrition and hydration (ANH) to an elderly patient through a central line because there is no other venous access and he is severely dehydrated. When treatment is not certain to save life and the burdens of the life sustaining treatment significantly outweigh any benefit, then it will be morally wrong and sinful to continue the treatment. If the harm is equal to benefit, then it will not be obligatory or sinful to continue but optional, for example lifesaving surgical operation on an elderly gentleman. Some may attempt to operate on balance of benefit and harm.

The table below shows how approaches to “religious obligations of treatment,” when withholding and withdrawing LST, are to be observed in view of certainty of effectiveness of treatment outcome and compounding harm considerations.

Continuing or withdrawing any particular treatment depends on the indication for that treatment and on the justification for limiting LST. It may be appropriate to limit some LSTs but not others on the basis of the burdens of treatment. For example, it may be appropriate to withhold invasive ventilation in a patient with a severe neuromuscular disorder, but obligatory to provide other less burdensome treatments, including non-invasive respiratory support, ANH, antibiotics, or blood transfusions.

Advanced technological application has led to treatments that can sustain life in circumstances where this was previously impossible. However, advanced treatments may be invasive, neither restoring health nor conferring overall benefits to the patient. LST or the underlying condition may produce pain and suffering for the patient and their families. Some of the most challenging and

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10 While central venous access is routine in the critically-ill patient, it is not without risk (see Kornbau et al. 2015).
emotionally complex decisions arise in relation to withholding, withdrawing or otherwise limiting treatment that has the potential to sustain life, but which imposes burdens or serious harms to the patient and family. So, how do we balance benefits of LST with that of harms from continued care and the underlying condition? Great progress has been made in obtaining reliable evidence on the beneficial effects of interventions, but developments in the identification, interpretation, and reporting of harmful effects is more challenging (Cuervo and Clarke 2003). What assessment and evaluations of harm should be made which serve patients’ best interests?

<table>
<thead>
<tr>
<th>Medical intervention</th>
<th>Certainty of medical intervention outcomes and their respective normative rulings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit</td>
<td>Harm</td>
</tr>
<tr>
<td>Level of certainty of effectiveness of treatment in saving life</td>
<td>Harm of intervention, in terms of hastening death or worsening severity of illness</td>
</tr>
<tr>
<td>Certainty (yaqīn) and dominant probability (ghalabt al-ẓann)</td>
<td>No harm or less harm than benefit</td>
</tr>
<tr>
<td></td>
<td>Greater harm then benefit</td>
</tr>
<tr>
<td></td>
<td>Equal harm with benefit</td>
</tr>
<tr>
<td>Presumption (ẓann), uncertainty (shakk), doubtfulness (wahm)</td>
<td>No harm or less harm than benefit</td>
</tr>
<tr>
<td></td>
<td>Greater harm then benefit</td>
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<td></td>
<td>Equal harm with benefit</td>
</tr>
</tbody>
</table>

Table 1: Certainty of medical intervention outcomes and their respective normative rulings
6 Limiting Treatment

The shorter a person’s future life, the less reason there is to provide LST. If the person is end-of-life because of a terminal illness, then certainty of prolonged or extended life cannot be achieved. The patient will soon die and hence it will not be obligatory to start or continue LST. Therefore, there is no obligation to initiate CPR or mechanical ventilation for a patient who is dying from terminal illness and is at end-of-life.

The statement of the Permanent Committee provides details of specific disease conditions that justify withholding life sustaining measures. It states:

If the patient is physically or mentally incapacitated whilst suffering from a chronic illness, advanced stage cancer, severe cardiopulmonary disease or has had several cardiac arrests, and the decision not to resuscitate has been reached by three competent specialist physicians, then it is permissible not to resuscitate.

AL-LAJNA AL-DĀ’IMA 1989

The Permanent Committee endorses withholding LST when permitting “Do Not Resuscitate” orders (DNR) in end stage chronic or terminal illnesses, with the agreement of three experienced doctors. In other words, if LST is unable or unlikely to prolong life significantly because the illness is terminal or chronically severe, then it is not in the patient’s best interests to provide it, i.e., it can be withheld. This describes futility based on the idea that life is limited in quantity because LST cannot prolong life significantly. These justifications can also extend to autonomous decisions of patients, families in cases of non-terminal illness also, when the patient has a serious permanently diminished neurological state and is likely to survive for a prolonged period, like being in a permanent coma, but there is no additional benefit with treatment. Treatment may be able to prolong life significantly but will not alleviate the burdens associated with illness, limiting quality of life (Larcher et al. 2015). This describes futility based on the idea that life is limited in quality or there is no meaningful life.

So, there are two important evaluations of life that require exploring when determining best interests of patients to forego LST:

1. Quantitative evaluations of life – whether the treatment will prolong the person’s life significantly.
2. Qualitative evaluations of life – whether the treatment will alleviate burdens of illness to provide a worthwhile quality of life or meaningful life.
These evaluations consist of both scientific and value judgements. When we assess suitability or responsiveness to treatment, we evaluate both the quantitative and qualitative components (Wilkinson 2019). Therefore, treatment becomes obligatory when there is a certainty that the patient's life is significantly prolonged, sustaining a worthwhile life.

7 Quantitative Evaluation of Life and Foregoing LST

If quantity of life is limited because of the underlying condition and there is inevitable or imminent death (Mahmūd Idrīs 2007), then LST can be withheld or withdrawn because of lack of benefit, as certainty of prolonged or extended life cannot be achieved. Classical Muslim jurists have described different levels or stages of end-of-life.

1. **Legal death**: The stage Muslim jurists refer to as al-ḥayāt ghayr al-mustaqirra. This is a state of permanent unconsciousness. Classical Muslim jurists give the example of a person who has been inflicted with serious illness or seriously wounded and is permanently unresponsive. The main diagnostic signs described are permanent loss of cognition, loss of coherent speech (nuṭq), sight (ibṣār) and voluntary movement (ḥaraka ikhtiyāriyya) (al-Jaʾṣṣās 2010, 5134; Ibn ʿAbidīn 1994, 6:455; Ibn al-Humām 2000, 6:6; al-Nawawī 2008, 9:146; al-Zarkashi 2000, 2:105; IIFA 1986, 523). The condition is described as irreversible and analogous to an animal after sacrificial slaughtering (ḥarakat al-madhbūḥ), when the sacrificed animal is legally or morally seen as dead even though there may be involuntary movements. This state is referred to as legal death (al-mawt al-ḥukmī) (al-Ramlī 2003, 7:263–264; al-Shirbīnī 1997, 4:31; Ibn ʿAbidīn 1994, 6:544; Ibn al-Humām 2000, 6:4–5; ʿIlhaysh 1984, 4:361; al-Kharshī n.d., 8:7–8; al-Nawawī 2008, 2:224; al-Qarāfī 1998, 2:33; Ḥaṭṭāb al-Ruʿaynī 2007, 6:244; al-Nawawī 1991, 5:146).

In medieval times, consciousness was not understood the way we understand it now, from a physiological or clinical perspective. The descriptions mentioned by classical Muslim jurists suggest that permanent cessation of sensory perception (volition, sentience) and voluntary action (i.e., higher brain functions) are determining factors in considering somebody as legally dead (al-mawt al-ḥukmī) or even close to it. Classical Muslim jurists differentiated between somatic signs of permanent loss of consciousness from that of biological or cellular death of the body when providing rulings related to death behaviours and penalties (Rashid 2021).
Starting or continuing LST provides no benefit in such patients and therefore, can be withheld or withdrawn. Death may be diagnosed following cardio-respiratory arrest, or in a permanently unconscious patient, it may be diagnosed following evidence of irreversible cessation of brain stem function. When death is diagnosed following formal confirmation of brain stem death by agreed medical criteria, intensive technological support is no longer appropriate and should be withdrawn.\footnote{Recognising that there are different criteria or standards for brain death for more detail see: (Rashid 2021).}

2. **Imminent death:** This is the stage of sakarāt al-mawt (al-Ghazālī 2005, 4:461), which is described as the final moments of death (nazā‘) and is the verge of the beginning of the death process when one is about to perish in their last moments. This state is not death and rulings of the living still apply. It is not permissible to speed the dying process through any means as a response to the person’s hardship (Ibn ʿĀbidīn 1994, 6:344; al-Qarāfī 1998, 2:31; Ḥaṭṭāb al-Ru‘aynī 2007, 6:244; al-Nawawī 1991, 5:146; al-Ramlī 2003, 7:263–4; al-Shirbīnī 1997, 4:38; Ibn Qudāma 1980, 7:835; al-Buhūṭī 1983, 5:516; Ibn Ḥazm n.d., 10:518). This state can be confused as death and treated as such. But reality is, it should not be considered death and should not be confused with legal death. Despite treatment, the patient is physiologically deteriorating. Continuing treatment may delay death but can no longer restore life or health. It is therefore no longer appropriate to provide LST because it is of no benefit and burdensome to do so.

3. **Inevitable demise:** The stage described as al-ḥayāt al-mustaqirra, which is during the last stages of life when death is unavoidable. Classical Muslim jurists give the example of a person who may have been inflicted with severe injuries and there is certainty or dominant probability that the patient will die within a few days due to underlying condition. The person has some cognition, can hear, see, talk and has some voluntary actions. This is a state where the soul is seen as having not departed and movements are voluntary (al-Zarkashī 2000, 2:105). This is a state of end-of-life or last days of life in the terminally ill. In some situations, death is not imminent (within minutes or hours) but will occur within a matter of days or even weeks. It may be possible to extend life by LST, but this may provide little or no overall benefit for the patient. In this case, there should be a shift of focus of care from life prolongation to palliation.
8 Qualitative Evaluation of Life and Foregoing LST

In some patients, continuing treatment may prolong life significantly. Yet it may be in the patient’s best interests to consider limiting it if there is no overall benefit in prolonging life because of the adverse impact entailed. Other than limited quantity of life, the states of limited quality of life due to underlying condition or illness, bear burden and harm and can also justify foregoing LST. Even when patients can survive for a long time, LST can be withheld or withdrawn when there is lack of ability to derive benefit because we cannot achieve a meaningful life. Qualitative evaluations assess the nature of a future life for an individual, the value and meaning that the patient will derive from it and the relative balance of positives and negatives. The positive impact of treatments on the patient’s ability to communicate, experience awareness of those around them, experience pleasure, attain goals and be independent, and the negative impact of treatment in terms of compounding harms like pain, discomfort, distress, violations of bodily dignity and loss of benefit to afterlife are important factors to be considered.

8.1 Compounding Harm Considerations

There are different types of harms and degrees of harm. In the Islamic bioethico-legal discourse, assessment of harm extends to other non-physical considerations like types of bodily dignity and loss of benefit to afterlife. I will first describe the types and degrees of harm and then propose an approach to be taken in considerations of harm expressed to bodily dignity and loss of benefit to afterlife.

Islam has a highly developed and sophisticated legal tradition, and Islamic law is the determining factor that Muslims seek authority from, which allows us to be able to make the right moral decisions (Sherman 2003). The balance and weight of harm outcomes are therefore to be dealt with from an Islamico-legal perspective, as this is what determines the overall permissibility of an act and what we “ought to” or “ought not to” do. In the Islamic legal tradition, harm is defined broadly when it describes setbacks to peoples’ interests related to reputation, property, privacy and liberty. In the legal literature the Arabic word ḍarar is commonly used to refer to harms to the physical human body and derives from ḍarra, which is mentioned in a number of verses of the Qurʾān either in the form of verb ḍarra – yaḍurru, noun ḍarrun or adverb ḍirāran. In the Qurʾān (Q 25:55, 5:76, 2:231, 20:89, 22:13) it takes a broad meaning, where ḍarar is defined as anything that causes damage or danger, and it is the opposite of benefit (nafʿ) (al-Rāzī 1986, 379; Fīrūzābādī 2005, 550). ḍarar has been interpreted by Muslim scholars in diverse ways, both in definition
and context. *Darar* can connote constriction and constraint (*ḍīq*) (Ibn Manẓūr 2010) or a state of affliction or difficulty. Al-Ṭabarī (d. 310/923) in his commentary describes *darar* as a state of extreme hardship and affliction (al-Ṭabarī 1994, 9:179, 20:170, 221). Al-Qurṭubi (d. 671/1273) and Ibn Kathīr (d. 774/1373) define it as severe poverty and hardship in life *al-faqr wa-l-ḍīq fī l-aysh* (Ibn Kathīr 1999, 3:229; al-Qurṭubi 2004, 6:426). The Qurʾān also describes *darar* as one which extends to emotional states (Q 39:8, 39:49). This is also the view of al-Rāzī (d. 604/1207) who also describes *darar* as grief, distress (*ḥuzn*) (Q 6:17); and extreme fear or adversity (*khawf shadid*) (al-Rāzī 1981, 12:494, 21:487).

A narrower focus on harm and one which is relevant here is harm considerations which present setbacks to physical bodily interests related to health and survival, and less to a psychosocial interest which are usually subjective and arbitrary (Nathan et al. 2020). Our discussion will address physical harms which are related to pain, psychological distress due to pain, functional disability and death more specifically on causing, permitting death, or risk of death – as the legal text relates harms to life and the human body in this manner.

Pain comes from an injury, either caused by the intervention or due to the underlying condition or illness and leads to diminished quality of life. If pain is severe, then this justifies withholding treatment if there is no benefit in

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12 Abū Jaʿfar Muḥammad b. Jarīr b. Yazīd al-Ṭabarī (d. 310/923) was an influential Sunnī Persian Muslim scholar, historian and exegete of the Qurʾān from Amol, Tabaristan (modern Mazandaran Province of Iran). His most influential and best-known works are his Qurʾānic commentary known as *Tafsīr al-Ṭabarī* which immediately won high regard and retained its importance for scholars to the present day. It is the earliest major running commentary of the Qurʾān to have survived in its original form.

13 Abū ʿAbd Allāh al-Qurṭubi (d. 671/1273) was an Andalusī jurist, Islamic scholar and *muhaddith* (*ḥadīth* expert). He was taught by prominent scholars of Córdoba, Spain and he is well known for his commentary of the Qurʾān named *Tafsīr al-Qurṭubi*. The most important and famous of his works, this 20-volume commentary has raised great interest, and has had many editions. It is often referred to as *al-jamiʿ li-ʿAbkām*, meaning ‘All the Judgments.’ Contrary to what this name implies, the commentary is not limited to verses dealing with legal issues but is a general interpretation of the whole of Qurʾān with a Mālikī point of view.

14 Abū ʿl-Fiḍāʾ ʿImād al-Dīn Ismāʿīl b. ʿUmar Ibn Kathīr al-Qurashi l-Damashqī (d. 774/1373), known as Ibn Kathīr, was a highly influential Sunnī historian, exegete and scholar during the Mamluk era in Syria. An expert on *tafsīr* (Qurʾānic exegesis) and *faqīh* (jurisprudence), he wrote several books, including a fourteen-volume universal history and his famous commentary on the Qurʾān named *Tafsīr al-Qurʾān al-ʿAzīm*.

15 Fakhr al-Dīn al-Rāzī (d. 604/1207) was a Persian polymath, Islamic scholar and a pioneer of inductive logic who made various works in the fields of medicine, chemistry, physics, astronomy, cosmology, literature, theology, ontology, philosophy, history and jurisprudence. One of his outstanding achievements was his unique interpretive work on the Qurʾān called *Mafātiḥ al-Ghayb* (“Keys to the Unseen”) and later nicknamed *Tafsīr al-Kabīr* (“The Great Commentary”).
treatment for the patient (Raffaeli and Arnaudo 2017). Whilst the Islamic tradition rewards individuals who bear pain during illness, supporting the notion that forbearance with pain is rewarded, the Prophetic statement in Islam states that there should be no harming or reciprocating of harm (lā ḍarar wa-lā ḍirār), which informs us that serious and irreversible harm from treatment should also be removed (Padela 2016). The psychosocial and functional consequences of chronic pain disorders are well documented as having significant effects on responsiveness to and participation in treatment, on functional disability, and health-related quality of life (Turk et al. 2016). Therefore, pain is an important physical factor which impacts our psychological and functional wellbeing, and in turn, affects treatment efficiency and outcome as well as our quality of life.

In the Islamic legal literature, competing harm considerations extend beyond the dimensions of personhood related to the physical body described in secular bioethics (Addis 2020). They also encompass events external to personhood, such as the sanctity of the human body. Actions such as tampering and violating the integrity dignity (ḥurma) of the human body are also recognised harms. For this reason, Muslim jurists commonly prohibit post-mortem autopsies and medical research on the human cadaver (Rispler-Chaim 1993). Classical Muslim jurists relate cases where violation of the sanctity or dignity of the human body is seen as a competing moral harm. Examples include the prohibition of dissecting a dead mother’s abdomen to extract a foetus when attempts of rescue are futile. Also the prohibition of dissecting and extracting another’s valuable property from the abdomen of a dead person who has swallowed the possession of another, and the prohibition of eating the human flesh of the dead even in a state of extreme starvation for survival (al-Kāsānī 2003, 5:229–130, 7:177; Ibn al-Humām 2003, 2:102; Saḥnūn 2014, 1:264; al-Dasūqī n.d. 1:429; al-Nawawī 2008, 5:270, 9:42–43; Ibn Qudāma 1980, 3:497–498, 13:338–339). In each of these cases the violation to the integrity dignity and sanctity of the dead human body through dissection, is for some, a weightier competing harm compared to other competing moral considerations like futile attempts at rescuing a foetus, the loss of the right of ownership of another, or even when rescuing self from starvation (Ibn Qudāma 1980, 2:413–414; Ibn Nujaym 1999, 88). The legal reasoning applied in the classical literature draws on legal maxims, where the sanctity and dignity of the violation of the body is weighed against other competing harms (adrār), when deciding which dominant harm is to be removed. Therefore, in an Islamic ethico-legal framework related to harm associated with LST, the sanctity and dignity of the human body must be preserved as much as possible when weighing harms and benefits of treatment.

Respect for bodily sanctity, dignity and integrity is generally viewed from two diverse views – the person-orientated and the body-orientated view (Rashid 2018). Modern bioethics gives more weight to the person-orientated view, which...
is based on respect of persons and autonomy (Rendtorff 2002). The body is of *instrumental* value and not *essential* value, and if mental life could survive outside the body, then the body would have no moral significance. Its value only exists in relation to the body being inhabited by the person. Once the person is removed, the body is just a shell that can be potentially used for other goods. This view employs an extrinsic value to the physical body. The *body*-orientated view refers mainly to duties to one’s own body rather than others. As a result, it can conflict with the *person*-orientated view, in that it is not always consistent with personal autonomy and self-determination. This intrinsic value to bodily integrity implies that our body is not entirely owned by us and that we are prohibited in doing certain things to our body that violate its dignity (*karāma*). This *body*-orientated approach is found mainly in religious doctrine such as the monotheistic traditions of Judaism, Christianity and Islam. It is also found in classical Greek and Roman thought, as well as in the works of philosophers such as Aquinas (d. 1274) and Kant (d. 1804) (Dekkers 2009, 340). This intrinsic value to the body view employs sacredness (*ḥurma*) to the body in a socio-political order, which extends to its natural, biological order (Ramsey 1970). The value of the body both living and dead is a sign of our dependence on it. It is a gift to be cherished and respected as inseparable from human dignity (Kass 1985, 278–294).

The Islamic legal tradition describes the human body as possessing *karāma* (dignity) and *ḥurma* (inviolability). Both these terms are described as closely related concepts (Padela 2016), and sometimes due to an inability to differentiate between the two, are used synonymously. Their distinction exists in their usage where *karāma* is a “right” conferred by God in the Qurʾān, which stresses that, “We have honoured (*karramnā*) the sons of Adam ... and conferred on them special favours [i.e., rights], above a great part of our creation” (Q 17:70). Whereas *ḥurma*, a verbal noun of *ḥaruma* relates to an “obligation or duty not to harm or violate” (i.e., prohibition) as the Qurʾān states: “And do not kill the soul which Allāh has forbidden (*ḥarram Allāhu*), except for just cause” (Q 17:33). A right is an entitlement not to be harmed whereas an obligation is something that one must do because of a law, necessity, or because it is a duty. Just as something may enjoy a right, there is an obligation on others towards it. The human body has a right or entitlement (*karāma*) not to be harmed or violated, and there is an obligation or prohibition (*ḥurma*) not to harm or violate.

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16 Two recognised rejectors of the significance of the human body are the theologian Joseph Fletcher (d. 1991) and the philosopher Tristram Engelhardt (d. 2018) (see Murray 1987, 1963–1967).
We are concerned with obligations related to harm to human bodily dignity which are physical harm considerations or violations (ḥurma) against the human body, through medical intervention. These come in many forms and are not to be seen as just a single broad concept. For example, Muslim jurists differentiate between different types of violations of dignity of the body. For example, dissection of the human body is seen morally different to using human body parts (i.e., as implants or transplants). The latter demands more stringent conditions compared to the former. Muslim jurists describe three main types or classifications of violations (ḥurma) to human body dignity in the fiqh literature, but there are more which hold less relevance to our discussion.¹⁷

1. The “integrity” ḥurma: This is normally described as mutilation (muthla) of the body. In other words, the human body is not to be physically mutilated and/or to be unjustly tampered with. Dissection, excision or removal of an organ or parts from an individual’s body, when there is no benefit for him, is considered mutilation (Sanbhali 1994, 1:188). This act, if it serves no purpose or benefit to the one whose body is violated, is prohibited in normal circumstances. The offence of mutilation extends to the dead corpse also, where both the dead and alive are equal in ḥurma. This is what is meant by the hadīth of the Prophet Muḥammad who said: “Breaking the bones of the dead is akin to breaking the bones of the living” (Abū Dāwūd 2000, 1464; Ibn Māja 2000, 2573), and “causing injury to a dead believer is similar to causing him injury when he is alive” (Sanbhali 1994, 1:188). There is general consensus amongst most contemporary scholars that such an act, if not excused in the Sharīʿa, is strictly prohibited (harâm) or at least disliked enough to be impermissible (makrūh) (al-Qāḍī Ḥamīd, 5:463; al-Mawwāq 1994, 4:548; al-Nawawi 2006, 1237; al-Shirāzī 1992, 3:282; Ibn Qudāma 1980, 9:327). Al-Shawkānī (d. 1255/1839)¹⁸ comments regarding the hadīth about breaking bones of the dead, that this hadīth identifies the caution required in ensuring that due care is taken in performing the ritual bath, shrouding, burial and other related acts, and that this applies to both Muslims and non-Muslims. He further states: “… if sin is committed against the cadaver, then there is no

¹⁷ There are also other prime descriptions related to the violation of human bodily dignity, such as bodily modesty ʿawra, ensuring the private parts of the body are always covered, but these descriptions are less relevant to the topic.

¹⁸ Muḥammad al-Shawkānī (d. 1255/1839) was a Yemeni scholar of Islam, jurist and reformer and called for a return to the textual sources of the Qurʾān and ḥadīth. He is credited with developing a series of syllabi for attaining various ranks of scholarship and used a strict system of legal analysis based on Sunni thought.
doubt that this is impermissible (fi taḥrīm). And if there is injury, then just as it is prohibited to cause injury to the living, it is prohibited to cause injury to the dead” (al-Shawkānī 2006, 4:34). To mutilate the human body is a culpable offence, and it is an obligation to refrain from this. Any kind of invasive intervention is to be considered a violation of the integrity component of human bodily dignity, requiring moral justification.

2. The “functional” ḥurma: This is normally described as harm (ḍarar) to the body, but the term ḍarar also refers to broader considerations including violations of mutilation to the body. Life is a gift from God and no one has the authority to destroy it without a justified cause acceptable to God. The functional component of our bodily dignity preserves life, and if the ḥurma of this functional component is harmed, then our life will suffer. God states in the Qurʾān: “Do not kill yourselves, for God is merciful to you” (Q 4:29), and “do not put yourself into destruction by your own hands” (Q 2:195). Suicide or any direct attempt to harm self is therefore prohibited, as this violates the functional dignity ḥurma of the human body. Allowing others to harm self, when there is no benefit for self or others, is also prohibited because the bearer of life cannot authorise to destroy self without the behest of the originator of life (God) (al-Qurṭubī 2004, 2:361, 5:150). The importance of preserving the functional component of bodily dignity is evident in many concessions (rukhṣa) that the Shariʿa grants in times of hardship.19 An example of such a concession is the permissibility of dry ablution (tayammum), as a prerequisite to daily prayers, in place of the obligatory wet ablution (wuḍūʿ). This is in cases where water is scarce or harmful and serves the purpose of preventing potential detriment to health. All these concessions are granted in the Shariʿa to preserve the functional component of our bodily dignity.20


20 Another example is the dispensation given to the frail, the pregnant and the ill, in keeping obligatory fasts, so as to preserve health and prevent harm. It is considered permissible for individuals to consume wine, to the extent necessary to avert harm. This is for the one who is choking whilst eating if no other drink is available. Other concessions are given for those who are weak and ill in performing their obligatory prayer and pilgrimage, and for the ill to consume unlawful medication when alternate forms of therapy are unavailable.
Pain and psychological trauma can be viewed as a functional harm if it interferes with a person's quality of life by diminishing their functioning capabilities (Breivik et al. 2008). Distinctions exist between the integrity component and the functional component of human bodily dignity, because the dead do not have a functional component. Their body has ceased to function in the worldly sense. This suggests that the functional component is specific only to the living.

An important distinction is the strength of the functional component compared to the integrity component.-violation of the integrity component to bodily dignity (mutilation) is tolerated and justified in order to preserve or maintain the functional component to bodily dignity on medical grounds if it is proven to be of benefit to the individual, i.e., having a surgical operation.

3. The objectification ḥurma: This is claimed on the basis that the entire universe has been created for the benefit of mankind. Within reason, man can use its resources to his benefit. “Indeed, We honoured mankind” (Q 17:70) and “It is He (God), who created for you, all that which is on the earth” (Q 2:29). It is undignified, if man's body or body parts are used, other than what God had ordained, as this would violate human bodily dignity and sanctity (Sayf Allāh 2004, 570; al-Sarakhsī 2005, 128). The Hanafi jurist Ibn Nujaym (d. 970/1563), states that, “... it is not permissible to sell or make use (intifāʿ) of human hair. This is because man is honoured (mukarram) and he is not to be defiled (mubtadhal). Therefore, it is not permissible that any part of his body is objectified in an undignified way (muhānan mubtadhalan)” (Ibn Nujaym 1997, 6:88). This description of harm to bodily dignity is extensively discussed in debates on organ transplantation and is not as relevant here.

Obligations of preventing harm do not just relate to obligations not to harm another, but also include obligations not to impose risks of harm, particularly with regards to treatment and non-treatment decisions. There are many examples of this in the fiqh literature, and legal maxims are used to guide

Many other concessions are present to prevent physical and functional harm to our body (see Ibn Nujaym 1999, 64–65).

21 The ḥurma of the living is weightier than the ḥurma of the deceased (see Jād al-Haqq 1983, 10:3702–3715).

22 Male circumcision is a religious ritual, which is also considered a weightier factor than the inviolability of the integrity component to bodily integrity.

23 Unless they re-affirm a ruling of the Qurʾān or Sunna, the legal maxims do not bind the jurist in delivering a judgment, but they do provide an important influence in exercising ijtihād in arriving at legal decisions (ḥukm) and opinions (fatwā). Legal maxims, like legal theories (naẓariyyāt fiqhiyya), are designed to elucidate a refined understanding of the subject matter rather than address enforcement. The legal maxims are not similar to ʿusūl

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how competing harms ought to be evaluated and judged (Ibn ‘Abd al-Salām n.d., 1:64–65). It is commonly accepted that there are five leading maxims in Islamic jurisprudence and one of them relates to harm principles, “harm must be eliminated” (al-ḍararu yuzāl) or otherwise described as, “there is to be no harm and no reciprocating harm” (lā ḍarar wa-lā ḍirār), which have subsidiary maxims (Ibn Nujaym 1999) (see Table. 10.1).

Classic Muslim jurists are all agreed on these principles of harm and associated maxims, but they differ in their application. The moral weight given to the violation of the dignity of the body varies in view of the facts relevant to each case (Yaseen 1990, 49–87, 56–57). For example, in the case of the mother who dies, and whether it is permissible to dissect her abdomen and rescue the foetus in her womb, Muslim jurists come to different conclusions from their legal reasoning. Either an attempt is made to rescue the foetus, by dissecting the mother and tolerating the violation of the integrity dignity of her body, or the integrity dignity of her body is not violated and the foetus not extracted, because rescuing the foetus is futile and serves no benefit. Violation of the integrity dignity of the mother’s body is seen an important competing moral feature, even when she is dead. Muslim jurists draw their conclusion using the maxim, “severe harm is to be removed by a lesser harm” (al-ḍarar al-ashadd yuzāl bi-l-ḍarar al-akhaff). The Ḥanafī and Shāfī’ī jurists permit the dissection of the mother to extract the foetus because even though the chance of survival

<table>
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<tr>
<th>Table 10.2 Maxims that relate to harm considerations</th>
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<tr>
<td>1. Harm should be removed to what is possible (al-ḍarar yudfa’ bi-qadr al-imkān)</td>
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<td>2. Harm should not be removed by another harm or by the same [degree of] harm (al-ḍarar lā yuzāl bi-l-ḍarar, al-ḍarar lā yuzāl bi-mithlih)</td>
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<tr>
<td>3. A more severe harm is to be removed by a lesser harm (al-ḍarar al-ashadd yuzāl bi-l-ḍarar al-akhaff)</td>
</tr>
<tr>
<td>4. Harm to an individual is tolerated in removing a public harm (yutaḥammal al-ḍarar al-khāss li-daf’ al-ḍarar al-‘āmm)</td>
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<tr>
<td>5. Avoiding [harm] detriment takes precedence over bringing about benefit (dar’ al-mafāsid awlā min jalb al-maṣālīh)</td>
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al-fiqh (principles of Islamic jurisprudence) since maxims are based on the fiqh itself and represent rules and principles that are derived from the detailed rules of fiqh on various issues. Uṣūl al-fiqh is concerned with the sources of law, the rules of interpretation, methodology of legal reasoning, dealing with the meaning and implication of commands and prohibitions and so on. On the other hand, a maxim is defined as “a general rule, which applies to all or most of its related particulars” (Kamali 2012).
of the foetus is small, attempts should be made because the preservation of the life of the living (i.e., functional dignity of the foetus) is weightier than that of the integrity dignity of the body of the dead (al-Samarqandî 1994, 3:345). Most of the Mālikī and Ḥanbalī jurists differ, because rescuing the foetus is of no benefit, and dissecting the mother serves no purpose except it violates her bodily dignity. However, if the mother is alive and the foetus is known to be dead, then all agree not to dissect the mother to extract the foetus, even if it means, dissecting and mutilating the foetus to extract it, as the functional ḥurma of the living supersedes the integrity ḥurma of the dead (Jād al-Ḥaqq 1983; Ibn al-Humām 2003, 2:142; Saḥnūn 2014, 1:264; al-Shirāzī 1992, 1:257; ‘Illaysh 1984, 1:532; Ibn Qudāma 1980, 2:410). Preserving the life of the mother supersedes preserving the integrity ḥurma of the dead foetus. There are other similar cases in the Islamic legal literature, where these harm maxims are used to determine normative opinions, after evaluating the moral weight of the ḥurma of the body to specific cases.

In summary, the human body has intrinsic value, which is an important competing harm consideration compared to what is seen in western bioethics. There is an obligation not to harm, where harm is seen more broadly in Islamic legal literature associated to violations of human bodily dignity related to the integrity and functional component. Diminished functioning due to physical harm, disability, pain and psychological trauma can all impact the functional ḥurma of the body, and the integrity component can only be violated if it benefits the functional component.

So how do these harm considerations relate to discussions around foregoing LST?

8.2 Harms and Burdens of Treatment

There is an obligation to maintain the functional component of bodily dignity at the cost of the integrity component if treatment benefit is certain. If there is uncertainty, but harms are minimised, then it is optional to continue LST. The use of invasive measures like mechanical ventilation in patients who will not benefit, swings the balance of harm, making the integrity dignity a weightier component to preserve. This is because there is little if any benefit to the functional component, or in fact the functional component may be diminished (Figure 10.1).

Duties associated with withdrawing LST fundamentally revolve around competing natures of preventing risk of harm, with the aim of providing functional benefit to the patient at the cost of tolerating violation to the integrity component of human bodily dignity. If there is no functional benefit and there is actual functional harm due to burden of intervention, leading to severe
pain or other adverse effects, then the violation of the integrity component is no longer justified. Rendering such an intervention normatively neutral, wrong and even prohibited. An example would be withholding CPR in the frail and elderly, which is not free from its burdens and risks. Decisions of DNR orders may be encouraged or may even be obligatory if harm significantly outweighs benefit. Both CPR, and the physiological process leading up to cardio-respiratory arrest, may have adverse consequences, for example, hypoxic brain damage and poor neurological outcomes. If it is unsuccessful, it may mean that death occurs in a traumatic and undignified manner and often in the absence of family.

Some forms of medical treatments in themselves cause pain and distress, which can be physical, psychological and emotional. If a patient’s life can only be sustained, but at the cost of significant pain and distress it may not be in their best interests to receive such treatment, especially if such treatment is not obligatory, for example, the use of invasive mechanical ventilation in severe irreversible neuromuscular disease in children. It is important that all options to relieve or overcome the negative effects of treatment are explored before proposing that it should be limited. However, if such treatment can only be delivered at the expense of compromising the patient’s consciousness, for example, by deep sedation, its potential benefit may be significantly reduced.

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24 CPR and resuscitative measures are with burdens and risks and include harmful side effects such as rib fracture and damage to internal organs; adverse clinical outcomes such as hypoxic brain damage; and other consequences for the patient such as increased physical disability. If the use of CPR is not successful in restarting the heart or breathing, and in restoring circulation, it may mean that the patient dies in an undignified and traumatic manner (see GMC 2010b).

25 Chronic pain is a significant problem in youths with neuromuscular disease NMD. Data strongly supports making comprehensive pain assessment and management an integral part of the standard of care for youths with NMD (see Engel et al. 2009).
Other examples of particularly high impact treatments include extracorporeal membrane oxygenation (ECMO), renal dialysis and, sometimes, intensive chemotherapy.

The professional duty to preserve life is not an absolute one that applies at all costs. Treatments should only be provided when they are in the patient’s best interests. Treatment which is medically inappropriate and cannot achieve its intended purpose, in preserving a meaningful life or restoring health, is no longer in the best interests of the patient, because its burdens outweigh the benefits.

8.3 Harms and Burdens of Underlying Condition or Illness

Life support is not treatment but just buys time. Life support and resuscitation refer to interventions, techniques and procedures to maintain life by artificially replacing the function of vital organs if needed. The objective is to buy time for patients so that they can be treated for the underlying cause or are able to recover on their own. Treatment becomes obligatory when there is certainty that the patient’s life is significantly prolonged, maintaining a worthwhile life. If the patient is not able to recover with life support to achieve a worthwhile or meaningful life with certainty – a life that can benefit the patient’s afterlife – then it no longer remains obligatory to continue. Therefore, treatment becomes obligatory when there is certainty that the patient’s life is significantly prolonged, maintaining a worthwhile or meaningful life and not merely just to rescue from death. Advances in technology allow us to keep patients’ vital organs sustained mechanically for prolonged periods, yet the patient does not benefit because his life has no meaning due to a severely diminished neurological state. The objective of LST is not to unduly prolong lives of patients in this state, nor is this something that the Shari’a demands. The Shari’a demands that we rescue patients so that they can live to benefit their afterlife by leading a life which is worthwhile and meaningful.

In Islam, a meaningful life suffices that the patient is able to be brought to a state of cognitive consciousness, where at the minimum, there is sustained volition, sentience and an ability to enjoy and interact with the world, even if cognitive functioning is diminished to the degree that the patient is not legally accountable in religion for his or her actions. This may be due to an incomplete legal cognitive capacity (ahlīyyat al-ʿadāʾ al-nāqiṣa) by Shari’a juristic standards. Aḥlīyyat al-ʿadāʾ al-nāqiṣa relates to a state of cognitive functioning where a person is not culpable and obligated to act on God’s commands. This is because their cognitive functioning has not matured for them to make their own decisions and to understand the implications of those decisions. They may have the ability to differentiate between good and bad (tamyīz) but do
not have the capacity to grasp the wider implications of their decisions. Even though this term specifically relates to legal culpability of children who have not achieved a level of maturity, i.e., when they have reached puberty (bulūgh), it is also used to describe both children and adults with reduced cognitive capacity (maʿtūh) like those with autism or dementia and would fall into the same ruling (ḥukm). In other words, it is not essential for the level of cognition to achieve a state of mukallafl where the patient is legally accountable for his actions, possessing ahliyyat al-adāʿ al-nāqiṣa (qualified legal cognitive capacity). Rather the state of incomplete legal cognitive capacity would also require us to rescue patients using LST.

It is only an obligation to initiate or continue resuscitative measures in patients where at least this minimum state of ahliyyat al-adāʿ al-kāmila can be achieved with dominant probability (ghalabat al-ẓann) (al-Zuhaylī 1989, 4:2968; Mullā Khusraw 2017, 2:441; Ibn al-Humām 1999, 2:176; al-Bukhārī 2009, 2:1394; Ibn ʿAbidin 1994, 5:100; Taftāzānī 1957, 2:168). If this level of certainty cannot be achieved, at this level of cognitive functioning and independent life,

26 A mukallafl in Islamic legal literature is described as the addressee of the Shariʿa (mukhāṭab al-sharīʿa) who is obligated to act by the commands of God because they have the capacity to follow the instructions of God in the Shariʿa and understand its implications. They have the cognition and will to do the right thing and the physical bodily means to act. This is to be differentiated from ahliyyat al-wujūh, which refers to rights one possesses and not obligations. Ahliyyat al-adāʿ al-kāmila (qualified cognitive capacity) refers to the level of capacity required to be considered mukallafl.

27 In response to Padela and Mohiuddin (2015), I would not recommend using the state of mukallafl here, as wilful actions can still occur in those not cognisant of their potential afterlife ramifications and conditions of God’s commands. Mukallafl actually refers to a legal state premised on the basis that an individual’s primary duty is to recognise and worship God and to gain reward in the afterlife. It is argued that this minimal religious utility is achieved when the person is able to distinguish between what is beneficial and harmful (tamyīz) and there is an adoption of righteous character (rushd). To consider such a state as the minimal standard obligated, to restore a person to a state of meaningful life, is problematic. First, there are potential harmful ramifications, i.e., slippery slope, when considering anyone who has a cognitive functional state below mukallafl as a life not worthwhile saving. Second, introducing broad exceptions to overcome this, such as using another end goal for children specifically, and those who have a non-mukallafl state prior to injury, doesn’t remove the idea that one is still accepting a non-mukallafl state as a life not worthwhile living /saving. Third, there are gaps and problems with such a construct related to mukallafl state, that the author recognises, but to then compensate by distorting the use of the term mukallafl to suit a status beyond just accountability of worship, and to include all worldly acts that gain divine pleasure and reward, renders the term mukallaf unsuitable for its actual original description coined by Muslim scholars.
then to forego LST and resuscitative measures in such patients will be permissible, optional and not culpable.  

A life is no longer meaningful if the person is unable to perceive, respond or engage with his/her environment indefinitely. To maintain or initiate resuscitative measures in such patients is of no value in fulfilling a worthwhile life as the patient is unable to achieve the minimum cognitive capacity or conscious state which is worth preserving. Higher functions of volition and sentience (iddāk) must be preserved, which are indications of the presence of the soul and a state when a person can engage with their environment. These higher functions are biologically attributed to the brain and not other parts of the body (Rashid 2021). To live such a life suffices one to enjoy life and be rewarded for acts of worship even though there is no obligation or culpability (al-Zuḥaylī 1989, 4:2968). They have voluntary movements, speech, vision,

28 This description also coheres with the description proposed by Schneiderman, Jecker and Jonsen that, “if a treatment merely preserves permanent unconsciousness or cannot end dependence on intensive medical care, the treatment should be considered futile” (Schneiderman et al. 1990).

<table>
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<tr>
<th>Quantitative evaluation of life and when foregoing treatment is permitted</th>
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<tr>
<td>Brain death (al-mawt al-ḥukmī)</td>
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<tr>
<td>Imminent death (sakarāt al-mawt)</td>
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<td>Inevitable death (al-ḥayāt al-mustaqirra)</td>
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<th>Qualitative evaluation of life when foregoing treatment is permitted</th>
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<tbody>
<tr>
<td>Burdens of treatment</td>
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<tr>
<td>Burdens of illness or underlying condition</td>
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a This guideline was co-authored by Dominic Wilkinson, who provided the original draft taxonomy and has been adjusted to suit ideas expressed in this chapter.
sensory perception and cognition. This would therefore, exclude permanent vegetative states (PVS)\textsuperscript{29} and permanent minimally conscious states (MCS)\textsuperscript{30} because these patients have severely diminished neurological states which fall far below the minimum standard required for incomplete legal cognitive capacity (\textit{ahliyyat al-adāʾ al-nāqiṣa}). It is therefore not an obligation to continue LST in these patients.

8.4 Harms and Burdens to Others

Value judgements related to LST extend to concerns of best interests for individuals and for society. Such concerns depend fundamentally on the normative balance of benefits and harms related to resource allocation of LSTs and its limitations at a societal level. There are only a finite number of specialist intensive care beds in health systems. Prolonged use of an intensive care bed after resuscitation may mean that another patient is unable to be admitted to intensive care. When a patient has an extremely low chance of ever recovering to benefit from that treatment, prolonged intensive care may be ethically difficult to justify. Those sorts of concerns can be very different in health systems that are privately funded, though even in those systems, resources are not infinite. The Islamic tradition views this from the perspective of individual rights (\textit{ḥaqq al-ʿabd}) of the patient \textit{vis-à-vis} rights related to public interests, i.e., rights of other patients who are also in need. Public rights are viewed from the perspective of God's rights (\textit{ḥaqq Allāh}), because God's rights require us to uphold some of our obligations to others or the public, even at the cost of our self-interest.\textsuperscript{31}

The human body is a joint right (a right of God and the individual),\textsuperscript{32} and any intervention that provides little or no benefit at the cost of significant harm, in

\textsuperscript{29}PVS is when it’s been more than 6 months if caused by a non-traumatic brain injury, or more than 12 months if caused by a traumatic brain injury.

\textsuperscript{30}MCS is when a person shows clear but minimal or inconsistent awareness. They may have periods where they can communicate or respond to commands, such as moving a finger when asked. A person may enter a MCS after being in a coma or vegetative state. In some cases a minimally conscious state is a stage on the route to recovery, but in others it’s permanent. As with vegetative state, a continuing minimally conscious state means it’s lasted longer than 4 weeks. But it’s more difficult to diagnose a permanent minimally conscious state. In most cases, a minimally conscious state isn’t usually considered to be permanent until it’s lasted several years.

\textsuperscript{31}The rights of God are not for the benefit of God, as He is above all wants, but they relate to public interest (\textit{al-nafʿ al-ʿāmm}). Their reference to God is because of their significant moral weight (‘\textit{īẓam khaṭarih}) and their general overall beneficial outcome (\textit{shumūl nafʿih}) in public welfare in comparison to other considerations.

\textsuperscript{32}Imām al-Sarakhsī (d. 490/1090) has classified these rights to four categories (al-Sarakhsī 2005, 2:289–303) (1) acts which are exclusively the rights of Almighty God (\textit{huqūq Allāh})
terms of pain, burden or distress, can potentially be seen as something wrong and culpable. Patient autonomy may be limited when seeking extreme measures which have little or no benefit to the patient, and the surrogate decision can be refused if it is seen that it is against the best interests of the patient, or even public interest if resources are limited. The balance of these rights will determine whether we can withhold or withdraw live saving treatment for patients. This balance is pivotal on factors which determine outcomes for the patient related to effectiveness of treatment relative to public need.

\[1\] Death here also includes states of permanent unconsciousness i.e. not achieved the minimum level of (ahliyyat al-adā’ al-nāqiṣa)

\[2\] Certainty here refers to dominant probability (ghalabat al-zann)

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**Figure 10.2** Flow chart showing a decision algorithm related to obligations of withholding and withdrawing LST
Questions of what treatments are in the patient’s clinical best interests must be separated from questions of available resources. Costs are an irrelevant consideration if a particular treatment clearly cannot provide overall benefit and is not in the patient’s best interests. Resource implications of providing treatment may be relevant in cases where the overall clinical benefit to the patient is open to debate and where provision of the treatment may pose significant risks of harm to the patient. Healthcare teams may therefore not be justified in providing treatments that are highly expensive or limited in availability and that appear to offer little benefit to the patient. Ideally, decisions to limit treatment should be based on clear and consistently applied policies developed at the institutional, local or community level. Any decisions to prioritise patients and treatments should be fair and based on the patient’s ability to benefit and should avoid discrimination, for example, race, age, gender, social status (Padela et al, 2021).33

Conclusion

Justifications for foregoing LST based on definitions or descriptions of futility are not helpful. What needs to be determined is whether it is an obligation, optional or wrong to withhold or withdraw LST, framed in duties or religious obligations for clinicians, patients and surrogate decision makers.

There is no moral distinction between actions of omission and commission when withholding and withdrawing LST. Any distinction claimed between them is not because of acting or not acting, but because of our duties and obligations to rescue patients, which depend on patient prognostic outcomes, and the balance of benefits versus compounding harms of treatment and the underlying patient condition.

The distinction that exists between duties and obligations to treat differentiating the two categories of LST – life-support and ANH, is associated with certainty of outcome of saving life, where ANH is certain to sustain life, whereas this is not always the case with life-support like CPR and mechanical ventilation.

The balance of benefit versus compounding harms from continued care ought to be assessed through quantitative and qualitative evaluations of life. This serves best interests of patients by assessing whether treatment will

33 For a more detailed overview of the Islamic stance to resource allocation of LST, see article on resource allocation (Padela et al. 2021).
prolong the person’s life significantly and alleviate burdens of illness, harm to others and provide a worthwhile quality of life or meaningful life.

Classical Muslim jurists have described states where there is seriously limited quantity of life and hence foregoing treatment is justified, because extending life is not certain. When patients are to survive for a prolonged period, LST can also be withheld or withdrawn when there is lack of ability to derive benefit, and the burdens of treatment illness or the underlying condition demand that we forego treatment.

It is only an obligation to initiate or continue resuscitative measures in those patients if the minimum state of *ahlīyyat al-ādā’ al-nāqīsa* can be achieved with dominant probability (*ghalabat al-ẓann*). If this level of certainty cannot be achieved at this level of cognitive functioning and independent life, then to withhold or withdraw LST treatment and resuscitative measures will be permissible, optional and not culpable.

Prolonged use of an intensive care bed after resuscitation may mean that another patient is unable to be admitted to intensive care. Where a patient has an extremely low chance of ever recovering to benefit from that treatment, prolonged intensive care may be ethically difficult to justify.

In many cases where treatment is of little or no benefit, redirection of management from LST to palliation represents a change in aims and objectives of treatment and does not constitute a withdrawal of care. If this is the case, then appropriate and effective palliative care should continue to be provided and it is not permissible for healthcare professionals to take active steps that are intended to end the life of a patient.

What is important is social acceptance of such redirection in management within an Islamic ethico-legal framework. Informed consent should be obtained and should include honest, caring, and culturally sensitive communication with family members, explanations of how interventions will be withheld, strategies for assessing and ensuring comfort, information about the patient’s expected length of survival, and solicitation of feedback and strong preferences about end-of-life care.

If the duty and obligations rationale is to be applied to withholding or indeed withdrawing medical interventions, practice guidelines for its use should be developed, and education about this approach ought to be incorporated into medical school, residency training, and continuing medical education programs. Muslim theological positions should also be incorporated recognising that not all LST are obligatory. If treatment is not obligatory, informed consent and informed refusal allow competent patients to choose among treatments in accordance with their values, goals, and priorities for their future (Curtis et al. 1995).
Bibliography


