Islamic ethical perspectives on life-sustaining treatments

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Historical background of brain death discussions

Deliberation about optimum use of life-sustaining treatments (LSTs) within the Islamic tradition arose from the broader discussions on whether brain death should be recognized as death from an Islamic perspective. From the 1980s, influential institutions adopted different positions on brain death, including the Islamic Organization for Medical Sciences (IOMS) in Kuwait in 1985 and 1996, the International Islamic Fiqh Academy (IIFA) in 1986, and the Islamic Fiqh Academy (IFA) in 1987; both based in Saudi Arabia. Despite their disagreement on the definition of death, the 3 institutions agreed that forgoing LSTs for patients diagnosed with brain death is justified from an Islamic perspective because brain-dead people would have no life to sustain. Some of those who did not recognize brain death as real death accepted the limitation of LSTs because of the irreversibility (*lā yurjā bur'uh* لا يرجى برؤه) of the patient's terminal condition. Although they regarded brain-dead persons as still living from an Islamic perspective, they conceded that these persons are in the process of dying, with no possibility to bring them back to stable life (*ḥayāh mustaqirra* [حياة مستقرة 5–1]).

Religious and ethical reasoning about LSTs

Cardiopulmonary resuscitation (CPR) and positive-pressure mechanical ventilation (PPMV) entered common practice in most developed countries in the 1960s and 1970s, and debates arose in western countries in the 1970s and 1980s about their benefits and harms in various clinical situations. In the Islamic world, based on widespread agreement, albeit for different reasons, that CPR and PPMV can be withheld from brain-dead people, the discussion broadened to address optimum care for patients with end-stage cancer or major organ failure who are not brain dead but whose best, or only available, therapeutic option appears to be palliative care. The *Islamic Code of Medical Ethics*, issued in 1981, is one of the early documents that mentioned this question, especially in the following passage:

> "In his defense of life, the physician is required to realize his limit and to abide thereby. If it is scientifically certain that life cannot be restored, then it is futile (*lā ṭā'il* لا طائل) to diligently maintain the vegetative state of the patient by means of artificial resuscitation or to preserve him by deep-freezing or other (artificial) methods. Ultimately, the aim is to preserve life not to prolong the dying process (*1*)".

The *Code* was clear about the categorical prohibition of active euthanasia and appended this passage by stating that "Doctor shall not take a positive measure to terminate the patient's life". The same position, which represents the mainstream position in the Islamic tradition, was reiterated in Article no. 61 of the International Islamic Code for Medical and Health Ethics (*6*). However, it is unclear in the passage whether "vegetative state" refers only to patients in a persistent or permanent vegetative state or also to those in a minimally conscious state or even patients with terminal illness. Further deliberations on this question produced 2 main positions in modern Islamic bioethics, whose proponents used different arguments and modes of reasoning. For the advocates of both positions, withholding and withdrawing LSTs are usually viewed as morally equivalent acts and thus will be used here interchangeably.

A minority position, advocated by some individual scholars, entails opposition to withholding/withdrawing LSTs for terminally ill (cancer) patients, including brain-dead persons, because these scholars consider them to be alive. Their argument is based on the sanctity of human life, a deeply rooted principle in the Islamic tradition, and the associated obligation of saving life. The sanctity of life principle in this context is premised on various Quranic verses that prohibit homicide, the most quoted of which is: "That is why We ordained for the Children of Israel that whoever takes a life—unless as a punishment for murder or mischief in the land—it will be as if they killed mankind entirely; and whoever saves a life, it will be as if they saved mankind entirely" (05:32). As for the Prophetic traditions or Sunna, the canonical collections, including those compiled by prominent traditionists like al-Bukhārī (d. 256/870) and Muslim (d. 261/875), are replete with like-minded statements. Based on this sanctity of life principle, some contemporary Muslim scholars oppose withholding/withdrawing these LSTs even from those deemed to be irreversibly unconscious or brain dead, suggesting that such determinations are exclusively medical and materialistic and thus fail to take

into account God's omnipotence, and His ability to heal any illness and reverse any condition. Such belief, they conclude, should make a Muslim confident that, with God's will, what is incurable or irreversible today can be curable and reversible tomorrow (5).

The majority position permits withholding LSTs under certain conditions. This position has wide support from Muslim physicians, many individual religious scholars, fatwas issued by national committees such as the Saudi Council of Senior Religious Scholars in 1989, the Dublin-based European Council for Fatwa and Research in 2001, the IOMS in 2004, and the IFA in 2015. Broadly speaking, the advocates of this position permit withholding LSTs once there is confirmation that the patient's illness, such as cancer, is irreversible, incurable and terminal, and that the LSTs in question are deemed to be more harmful than beneficial, or of no benefit at all, as for some end-stage cancer patients. Additionally, the fulfilment of these conditions should be confirmed by three competent and trustworthy physicians (5–7). In the case of incapacitated patients, the assigned guardians should be involved to obtain their informed consent (6).

The advocates of this position argue that medical treatment (*tadāwī*) is in principle permissible and that LSTs would only be obligatory under certain conditions that are not fulfilled in this context. The right perception of LSTs in the case of irreversibly and terminally ill patients is that they are a life-preserving measure rather than a life-saving treatment. Although one should always believe in God's omniscience and omnipotence, respect for reliable medical knowledge and taking one's decisions accordingly are recurrently encouraged in both the Quran and Sunna. Available medical knowledge shows that some patients could be reaching the end of their lives. In other words, they could be facing the irreversible dying process (*iḥtiḍār* الإحتضار) in the Islamic tradition, which may be characterized by severe agonies and pains. The dying process, with its associated agonies, was the subject of distinct chapters in the canonical collections of prophetic traditions. For instance, the famous authoritative collection compiled by al-Bukhārī (d. 256/870) has a distinct section entitled "Agonies of Death (*sakarāt al-mawt* سكرات الموت)". In such cases, LSTs will not be a means to save life but they will prolong the dying process and exacerbate suffering. Therefore, LSTs would in these situations conflict with the core Islamic values of mercy and compassion. Additionally, the unregulated use of such expensive and scarce resources, when they are judged as nonbeneficial or more harmful than beneficial, may result in further financial and medical harms for broader society (5–7).

Conclusions

The Islamic bioethical deliberations on LSTs are rich and diverse and they have assumed an institutionalized form since the 1980s. These extended discussions eventually produced a mainstream position, widely supported by physicians and religious scholars, that withholding/withdrawing LSTs for terminal patients is permissible under certain conditions, especially when LSTs are judged as more harmful than beneficial. However, further challenging questions are in need of critical examination; for example, how should physicians, patients and family members engage optimally in shared decision-making about the benefits and harms of LSTs, especially when these various stakeholders disagree? Which roles should the physician's medical knowledge and patient's moral worldview play in determining the relative benefits and harms of LSTs in concrete situations? Finally, there is an urgent need to translate the outcome of this ethical discourse into regulations and enforceable laws in Muslim-majority countries so that physicians have more clarity about what (not) to do in practice and how the question of liability will be settled if controversial cases go to court.

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