Reframing Islamic Bioethics

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Among Muslims today, there has been an ambivalent response to what we might call bioethics. Some argue that the Islamic tradition has its own ethical norms, and that therefore there should be a separate field, "Islamic bioethics," gleaned from the fatwas of religious scholars (muftis) in Muslim countries about the permissibility of certain medical technologies. Others argue that both medicine and a "common morality" are universal, and that therefore an ethical doctor's advice matters more than that of a shaykh, or religious scholar. In this post I argue that neither of these are valid arguments.

First, why would a single fatwa written by an Islamic scholar (most often within the confines of state bureaucracies and political pressures in the Muslim world) comprise *the* ultimate Islamic position on complex bioethical conundrums? On what bases did the mufti issuing the fatwa formulate his opinion?

Bioethical decisions are often based on cost-benefit analyses of a given medical procedure — but who gets to determine what cost is tolerable, and what benefit makes the cost worth it? And on what bases? People will necessarily have different experiences, perceptions, and stakes in these calculations.

Various constituents — from Muslim leaders, to academics, to UNESCO, to hospital administrators in Euro-American countries flummoxed about how to manage their Muslim patients — have sought to understand what "Islamic bioethics" might say about various topics such as organ transplantation or in vitro fertilization. Yet in trying to find out how a particular culture or religion approaches a bioethical topic, we risk overstating the homogeneity of opinion and silencing the voices of the marginalized.

Secondly, as Paul Farmer has pointed out, bioethics has been limited by a myopic set of questions that has had little to say about global inequalities underlying health disparities. Bioethics emerged in the U.S. as a field in the 1960s as a critical external power check on medical institutions and to advocate for the vulnerable position of patients and subjects of medical experimentation. Yet, in the subsequent decades, bioethics became institutionalized within biomedicine, serving more to justify than to question medical norms and to manage rather than address inequalities.

Let's look, for example, at the case of a father dying of liver failure in Egypt, and his adult son who is eager to donate a liver lobe to him in the hope that a lobe transplant will lengthen his father's life and ease his suffering. The surgery is risky to the healthy donor. Ever since the first living human kidney transplant in 1954 at Peter Bent Hospital in Boston, the Hippocratic Oath to "do no harm" has had to be violated. In Egypt, this debate has been framed by the media as a disagreement between "medical" and "religious" fields. But medical specialists do not speak in one voice on the relative risks of liver lobe extraction to the healthy donor, or the chances of success in cases of complicated liver disease.

Why not use the liver from a deceased person? This might relieve us of the risk of harming a healthy donor. In Egypt and many other countries, however, death is declared according to cardio-pulmonary criteria. For liver transplantation in the U.S. and European countries, the "deceased" donor is in fact a patient whose brain function has ceased, but whose body and organs are kept biologically functioning via a ventilator. Egypt's muftis and physicians have argued for years about the ethics of declaring a brain-dead patient "dead" for the purposes of organ extraction.

Contextualizing Bioethical Questions

While these types of questions are recognizably the stuff of "bioethics," they barely skim the surface of deep structures of global inequality that value some lives over others. If we return to the father-son case and liver failure, we might first ask: why is there such an epidemic of liver failure throughout Egypt?

Egyptian environmentalists have demonstrated that state management of water systems, including damming projects and the maintenance of irrigation canals, plays an important role in disease incidence. The ambitious construction in 1970 of the Aswan High Dam under a politically repressive military dictatorship provided hydroelectricity throughout the nation. Yet it also dramatically reduced water flow and the movement of the richly fertile Nile silt. Farmers were thus compelled to depend on chemical fertilizers and pesticides that led to weed flourishing, blocked waterways, and caused water stagnation — the ideal habitat for the vector of schistosomiasis (also called bilharzia), a parasitic infection that wreaks havoc on the internal organs.

Increased evapotranspiration further degraded water quality. In an effort to respond to increased schistosomiasis infection in the 1970s, the Egyptian state launched a massive campaign in which public health officers went from door to door in villages up and down the Nile, dispensing tartar emetic injections as preventative therapy. Although it was yet to be discovered at the time, the virus hepatitis C survived the attempted sterilization of the needles via boiling, and the public health campaign inadvertently infected a large portion of the Egyptian population — somewhere between ten and thirty percent — with hepatitis C, a disease that can ultimately

destroy the liver, which may already be compromised by the toxic use of chemical fertilizers, pesticides, schistosomiasis, and poor water quality.

Where were the voices of bioethicists — whether religious or secular — when it came time to assessing the human costs and benefits of building the Aswan High Dam, and the resulting permanent re-structuring of the ecology and landscape? Where were the appeals to Islamic norms of social justice, of humility toward God's creation and stewardship of the environment? Where were the voices of ethicists in assessing the ambitious public health campaign that yielded unintended disastrous results? What we find in this example is further evidence that the field of bioethics – in secular and religious forms – often arrives to the scene too late. And it continues to focus on small-scale questions ("Is it ethical to transplant a liver lobe?") when liver transplants, ethical or not, will never be able to alleviate a national-epidemic at the scale of Egypt's liver disease problem. There are simply not enough organs, surgeons, or resources.

Reframing Bioethics

Whether secular or religious, it is clear that bioethics needs to be reframed, and can only go forward by incorporating multiple voices from different scholarly disciplines, fields of expertise, and different strata of social life. A fatwa from a mufti in a Muslim-majority country doesn't make bioethics "Islamic." And a bioethicists' pronouncement on a medical procedure such as liver transplant doesn't begin to address the underlying forces predisposing vulnerable populations to disease. Bioethics needs to look beyond the cutting-edge life-or-death scenarios and speak to the everyday inequalities of politically mismanaged and economically vanquished societies. The struggle for a world of greater social justice, equality, peace, and environmental health requires more from Muslims than following fatwas, or identifying with things labeled "Islamic." Our surest path toward greater social justice is the continual insistence on the sanctity of life — *all* lives — even, and especially, in the face of political oppression and economic exploitation.

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