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Islamic perspectives on clinical intervention near the end-of-life: We can but must we?

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Abstract The ever-increasing technological advances of modern medicine have increased physicians' capacity to carry out a wide array of clinical interventions near the end-of-life. These new procedures have resulted in new "types" of living where a patient's cognitive functions are severely diminished although many physiological functions remain active. In this biomedical context, patients, surrogate decision-makers, and clinicians all struggle with decisions about what clinical interventions to pursue and when therapeutic intent should be replaced with palliative goals of care. For some patients and clinicians, religious teachings about the duty to seek medical care and the care of the dying offer ethical guidance when faced with such choices. Accordingly, this paper argues that traditional Sunni Islamic ethico-legal views on the obligation to seek medical care and Islamic theological concepts of human dignity (karāmah) and inviolability (ḥurmah) provide the ethical grounds for non-intervention at the end-of-life and can help calibrate goals of care discussions for Muslim patients. In closing the paper highlights the pressing need to develop a holistic ethics of healthcare of the dying from an Islamic perspective that brings together multiple genres of the Islamic intellectual tradition so that it can meet the needs of the patients, clinicians and Muslim religious leaders interacting with the healthcare system.

Keywords Religion · Bioethics · Human dignity · Islamic law · Palliative care

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Introduction

Novel technological advances in science and medicine provide physicians with a greater number of tools and an increased capacity to restore and supplant the functions of human organs. In light of these newfound capabilities, much ink is being spent discussing the ethics of end-of-life healthcare. On one hand, the technical powers of biomedicine are clearly life-saving. Motor vehicle accident victims who present with intracranial hemorrhage, for example, now have a chance at survival and at returning to normal functioning due to surgical and technological innovations. Yet, at the same time, increased scientific knowledge and technical prowess can result in outcomes that are ambiguous where patients linger in minimally conscious states within nursing facilities. Dramatic technical advances have also enabled biomedicine to socio-culturally construct (or label new) "states" of life and "types" of death, including persistent vegetative state, brain death, and the donor after cardiac death. These new constructions can and usually do obscure previously clear distinctions between the living and the dead. These physiological states and types of life and death, whether resulting from prior clinical interventions or servicing future ones, are sites of moral entanglement and ethical dilemmas.

In this clinical context religious traditions may help clinicians, patients and other healthcare stakeholders to

perform the moral calculus related to clinical intervention near the end-of-life by defining human life and describing a life worth medically maintaining. Religious ethical frameworks also assist in healthcare decision-making by demonstrating how scriptural source-texts and religious teachings can be used to evaluate the merits of medical intervention in a rapidly changing biomedical landscape. Accordingly, this paper addresses the moral dimensions of medical practice near the end-of-life from an Islamic perspective.

Like other communities, Muslim patients, clinicians and Islamic scholars grapple with questions about the ethical obligations of providers and families during end-of-life healthcare, and they struggle with the clinical uncertainties related to the shifting borders between life and death. For example, a qualitative study of immigrant Muslim physicians in the United States found there to be tensions between their faith and end-of-life care as participants felt "(withdrawal) would be against the religion." (Padela et al. 2008, p. 367) Confirming that American Muslim physicians are challenged by of end-of-life clinical decision-making, a recent national survey reported that 70 % of respondents felt withdrawing life-sustaining treatment caused greater psychological distress than withholding it. The survey also identified additional sources of tension between Islamic values and contemporary end-of-life care as nearly 50 % of respondents were unsure whether brain death signifies true death according to Islam nor whether it permitted feeding tubes to be withdrawn. (Padela, unpublished data) Even in Saudi Arabia where brain death is considered death by law, a longitudinal study of brain-dead patients found that terminal extubation took place only among a small minority, and that Muslim families were conflicted about limiting clinical interventions for brain-dead family members (Khalid et al. 2013).

Brain death is a source of much controversy within the Islamic juridical community and debates over brain death illustrate the struggle religious leaders face in providing ethical guidance for end-of-life healthcare. Over the past several decades, prominent Islamic juridical councils across the globe have taken up the question of whether brain death can be considered ontological death and whether the clinical criteria suffice for legal death within Islam. Some accept brain death as legal death in Islam, others consider it to be a dying state, whereas a minority reject brain death as death (Farah and Al-Kurdi 2006; Padela et al. 2013; Padela and Basser 2012; Padela et al. 2011; Sachedina; Tavakkoli 2008; Moosa 1999; Ebrahim 1998). Consequently, while the former two camps find it ethico-legally permissible to withdraw life support from brain dead patients, the latter does not (Miller 2015; Padela et al. 2013). As the science around brain death is further clarified and clinical practice guidelines for assessing brain death continue to evolve, both Muslim clinicians and ethicists have called for revisiting Islamic perspectives on brain death (Qazi et al. 2013; Rady and Verheijde 2013; Padela et al. 2011; Miller et al. 2014; Hamdy 2013; Moosa 1999; Bedir and Aksoy 2011).

These studies illustrate that healthcare at the end-of-life is fraught with multiple ethical challenges for Muslim patients, providers and religious leaders. This paper aims to provide some guidance and advances to the bioethical discourse regarding healthcare for the imminently dying by retrieving classical Sunni juridical perspectives on whether Muslims are obligated to seek medical care and discussing Islamic theological correlates for human dignity and inviolability. Our review of Islamic legal opinions will demonstrate how clinical intervention is, in general, not morally obligated upon Muslims, and our discussion of human dignity and inviolability will suggest that these constructs provide a counter-weight to continued clinical interventions near the end-of-life. Finally, the paper will close by commenting on the urgent need for a theologically-rooted, holistic bioethics of caring for the dying from an Islamic perspective in order to better serve Muslim physicians and patients.

The moral status of seeking medical care in Sunni Islam

Before proceeding to describe Islamic ethico-legal perspectives on seeking medical care a few limitations must be presented, and a few critical terms need to be defined. Islam is divided into two major theological sects: Sunni and Shia, with approximately 85 % of Muslims considering themselves to be Sunni (Mapping the Global Muslim Population 2009). While Sunni and Shia theology share much in common, they differ on who they consider as authorities for scriptural transmission and interpretation as well as on the role of reason in determining moral obligations. Accordingly, each sect has its own distinctive moral theology (*uṣūl al-fiqh*).[1] A *madhhab*, or a school of law, in the Islamic legal tradition consists of a body of legal opinions and hermeneutics developed by the eponymous

[1] We adopt Prof. Mohamed Fadel's usage of the English term moral theology to refer to the Islamic science of *uṣūl al-fiqh*. (M. Fadel, "The True, the Good and the Reasonable: The Theological and Ethical Roots of Public Reason in Islamic Law." *Canadian Journal of Law and Jurisprudence*, vol. 21/1, 2008). As Prof. Fadel notes in so far as *uṣūl al-fiqh* is concerned with the scriptural sources of moral obligation, the processes of moral assessment, and moral epistemology it is a moral science. And since *uṣūl al-fiqh* is primarily concerned with how God judges human acts and strives to reach the truth regarding moral propositions it is a theological discipline. Consequently the mapping of terms is apropos even if not precise. I use the terms "Islamic ethico-legal tradition" and "Islamic law" to refer to the notions of *fiqh* and *aḥkām taklīfiyya* interchangeably.

founder of the school. The term applies to the founder's legal opinions as well as the opinion of jurists who subscribed to the hermeneutic of the school. This paper presents arguments from the Sunni schools of law because they derive their ethico-legal positions using, more or less, the same scriptural sources and tools, and they mutually recognize each other's truth claims (Kamali 2003). The four extant schools of law within Sunni Islam are Ḥanafī, Mālikī, Shafiʿī, and Ḥanbalī.

Islamic moral theology (*uṣūl al-fiqh*) stems primarily from two scriptural sources: the Qur'ān and the normative practice of the Prophet Muḥammad (*sunna*). Both of these sources are a part of the same revelatory transmission and are thus classified as divine communication (*waḥy*) (Doi 1984). Using these two sources as the fountainheads for moral duties, Islamic scholars have elaborated a science, an Islamic moral theology—*uṣūl al-fiqh*—by which to assess actions along a moral gradient from obligatory to forbidden (Fadel 2008).[2] An assessment of this type is termed *ḥukm taklīfī*, and it links human action to expected afterlife ramifications—God's reward, punishment, or indifference (Kamali 2003). Importantly, the moral status of actions is determined by examining the posited afterlife ramifications of an act through study of scriptural source-texts.

In this paper we present the *aḥkām*, ethico-legal rulings, about the moral status of seeking medical treatment from the four schools of Sunni law. In presenting these stances we draw on positions of authoritative jurists as recorded in standard legal manuals and instructional *fatāwā* compendia used within seminaries for teaching legal theory and sources that are representative of the major verdicts of a particular school. This selection is necessary because within any *madhhab* one may encounter multiple viable legal positions on any given issue, all of these positions having been derived by using the particular ethico-legal theory and constructs of that school. Given this diversity each school has developed a framework that provides a hierarchy of authorities and a categorization schema that allows for navigating the multiple opinions. For example, the term *al-aẓhar* refers to the strongest position among the various legal positions held by al-Shafiʿī on a particular issue, whereas the term *al-aṣaḥ* refers to the "most correct" position according to the jurists associated with the Shafiʿī but it is not the position of al-Shafiʿī himself. In this study, we examine the authoritative works of each school and work with the positions that jurists of the school have identified as the strongest.

While our purposive sampling provides insight into a normative an Islamic ethico-legal perspective and represents the prevailing position within a particular legal school, we acknowledge that secondary and non-dominant positions within these schools merit detailed study. Indeed the diversity of positions within a school allows for jurists to use their discretion for penning *fatāwā* that remain within the bounds of a school's scholarly lineage yet at the same time attend to the contextual factors that weigh upon the one seeking the *fatwa*. Studying such *fatāwā* can yield insights into the creativity employed by jurists when confronted by ethical challenges accompanying scientific advancements. Yet, *fatāwā* may prioritize contingencies and adopt minor positions from within (or even from outside of) the legal schools, *fatāwā* can represent exceptions to the rule. Because we desired to focus on the "rule" and not exceptions or ethico-legal innovations we restrict our discussion to *fatāwā* compendia used for ethico-legal instruction and do not venture into modern *fatāwā* collections of jurists operating outside of the school structure.[3]

Finally it bears mention that modernity has challenged notions of Islamic normativity and that the seminary, as well as *madhhab*, authority is hotly contested in the contemporary period. The *uṣulī* approach to ethico-legal judgment utilized by many seminarians is deemed as outmoded by scholars and new approaches such as *fiqh al-aqalliyāt* (jurisprudence for Muslim minorities) or embellishments of different genres of Islamic law such as the *maqaṣid al-shar'iah*, are offered as alternative frameworks for deriving ethico-legal injunctions (Auda 2008; Attia 2007; ʻAlwānī and Shamis 2010). While we acknowledge these "newer" approaches to deriving Islamic ethico-legal stances and the reasoned critique of the legal school paradigm, the schools of law remain an authoritative source that informs the new approaches themselves and for present-day Muslims (both jurists and laity) around the world as they furnish the inherited canon. As such we hold that they are a key source to study when constructing an Islamic bioethics.

It also bears mention that many state and civic organizations as well as transnational bodies routinely convene juridical councils to offer Islamic legal guidance. These modern councils comprise of jurists of varied backgrounds and legal persuasions, and operate on the basis of collective *ijtihād (jamaʿī)*, which allows for drawing eclectically upon the conventions and constructs of the schools of law (Karman 2011). While the resolutions of these councils provide critical insight into how jurists balance classical positions with modern contexts, since the ethico-legal

[2] This gradient ranges from obligatory (*farḍ* or *wājib)* to recommended (*mandūb* or *mustaḥab)* to permitted (*mubāḥ*) to discouraged (*makrūḥ*) and, finally, to prohibited (*ḥarām*).

[3] For a classification schema of the different types of *fatāwā* see Skovgaard-Petersen, J. (2015). A Typology of Fatwas. Die Welt des Islams, 55(3–4), 278–285, and for insights into legal manuals used for seminary instruction in Islamic law see Fadel, M. (1996). The Social Logic of Taqlīd and the Rise of the Mukhataṣar. Islamic Law and Society, 3(2), 193–233.

methodology operating in the deliberation chamber is ambiguous, and the linkage between the resolutions and the schools of law is tenuous, the judgments of such councils do not suffice as primary sources for the present study. Rather, pertinent resolutions are mentioned in a complementary fashion below.

The scriptural source-texts

The reader will benefit from a description of the key scriptural source-texts at the heart of the debate of whether seeking medical care is obligated in Islam. The Qur'an unequivocally ascribes healing as an act of God as it quotes the Prophet Abraham saying "And when I am ill, it is He [God] who cures me" [26:80] (Ali 1999). Statements from the Prophet Muhammad also relate that illness and cure are from God (see below). At the same time the Prophet described a group of people who will enter paradise without being reckoning saying that, "they have never allowed themselves to be treated by cauterization…rather, they have put their reliance in God alone" (al-Bukhari 2002, 1610). Importantly, the Prophet described the reward for avoiding cauterization, a common medical treatment at the time, as entry into paradise. This statement creates tension with other statements of Prophet which instruct believers to pursue medical care. For example one narration states, "seek medical treatment, for except for senility, God has not created an illness except that He also created its cure" (al-Sijistānī 2009, 6:5). These statements suggest that Muslims are encouraged to seek medical treatment but they also have a reward for abstaining. Against the backdrop of these scriptural sources the prevailing opinion within each of the Sunni schools of law is described below.

The Ḥanafī school of law

According to the Ḥanafī school seeking medical treatment is not obligatory even if one dies because of this non-action. This position is expressed in several legal manuals (*mutūn*) such as *al-Mukhtār* of al-Mawṣilī (d. 683/1284) and *Multaqā al-Abḥur* of Ibrāhīm al-Ḥalabī (d. 956/1550). For example, al-Mawṣilī's *al-Ikhtiyār*, his commentary on *al-Mukhtār*, and Dāmād Afandī's (d. 1078/1667) *Majmaʿ al-Anhur*, a commentary on *Multaqā al-abḥur* recall the ruling that that there is no sin upon the one who does not seek medical treatment, and then clarify that this determination has been made "because there is no certainty that this treatment will cure him and it is possible that he will become well without treatment" (al-Mawṣilī, 2:409–10; Dāmād Afandī 1910, 2:525). Prominent *fatāwā* collections within the school also corroborate this position. Illustratively, *al-Fatāwā al-Hindiyyah* cites *Fatāwā Qādīkhān* and states that if a doctor tells the patient that he needs a certain treatment, and the patient refuses the treatment and subsequently dies, the patient has not sinned (Niẓām 2009). The rationale underlying this position is stated in several *taʿlīl* works (monographs that detail the evidence and rationale behind ethico-legal rulings). Badr al-Dīn al-Simāwī's (d. 823/1420) *Jāmiʿ al-fuṣūlayn*, expands on this point. The text mentions that the removal of harm by action can be either certain (*maqtūʿun bihi*) or probable (*maẓnūn*) or doubtful (*mawhūm*). Eating and drinking to relieve hunger and thirst (both representing harms) are actions that lead to the certain removal of hunger and thirst, however medical treatment is from the second (probable) category and therefore refusal is not sinful. (al-Simāwī 1882) Importantly al-Simāwī mentions a possible exception to this rule stating that if an individual knows by personal experience that a specific treatment will *certainly* remove the harm caused by disease then for this person *that particular treatment* may be obligatory to use. Given that 100 % clinical efficacy is rare the potential zone of moral obligation to seek medical treatment appears to be small according to the Ḥanafī construct.

The Shafiʿī school of law

The foremost authorities for legal opinions in the Shafiʿī school of law are Ibn Ḥajar al-Haytamī (d. 974/1566-67) and Muḥammad ibn Aḥmad al-Ramlī (d. 1004/1596) whose legal opinions are found in their commentaries on the school's central legal text, *Minhāj al-Ṭālibīn* by al-Nawawī (d. 676/1277). These authorities state the default ruling in the Shafiʿī school on seeking medical treatment is that it is a recommended, but non-obligatory, act. For example, al-Haytamī comments

> Seeking medical treatment is recommended based on the rigorously authenticated report (of the Prophet Muhammad), 'Seek medical treatment. For, except for senility, God has not created an illness except that He also created its cure.' And in another rigorously authenticated transmission it states, 'God has not sent an illness except that He also sent its cure.' If one avoided medical treatment trusting [in God], then it is a virtuous act (*fa huwa faḍīlah*). The author (al-Nawawī) stated this. al-Adhraʿī considered [a person who does not seek treatment] to be superior explaining that if a person's trust is strong then it is better for him to not [seek medical treatment] but if [a person's trust] is not [strong], then [seeking treatment] is better…Qāḍī ʿĪyāḍ (another authority in the Shafi school) has transmitted that there is consensus (*ijmāʿ*) that seeking medical treatment is not obligatory. This [claim] is opposed by some scholars of our

school holding that it is obligatory [to seek medical treatment] in the case of a person who had a wound which they feared would lead to death (*yukhāfu minhu al-talaf*). [The case of medical treatment being recommended] differs from it being obligatory such as in the case of swallowing wine when choking or to apply a dressing to the phlebotomy site because of the certainty of its benefit (*li tayaqqun nafʿihi*) (al-Shirwānī 1972, vol. 3 pp. 182–83).

In this passage al-Haytamī presents the default ruling in the Shafiʿī school by interpreting Prophetic directives to seek medicine as evidencing a recommendation to seek treatment. He admits that there are some scholars who consider seeking medical treatment to be an ethically obligated act, i.e. sinful if not performed, but notes that they elevate the moral status from recommendation to obligation only when leaving medical treatment would lead to death and there is certainty in the clinical efficacy of a particular medical treatment preventing death. According to al-Haythamī, while seeking medical treatment is generally recommended, if the certainty of its benefit exists then recourse to medical treatment becomes obligatory. Further explaining why Shafiʿī jurists held seeking medical treatment to be recommended but not obligated, al-Ramlī explains "seeking treatment is not obligatory, contrary to [the case of] one compelled to eat from a corpse and [the case of one] washing down a morsel of food with wine, due to the lack of certainty (*al-qaṭʿ*) in it being effective, which is contrary to these two cases" (al-Ramlī 1967, vol. 3 p. 19).

Somewhat muddying the waters however is that some Shafiʿī authorities deem the high probability (*al-ẓann al-ghālib*) of an illness occurring as sufficient to make the act of *not* utilizing clinical treatment sinful. Consequently avoiding sickness becomes obligatory. For example, in the case of dry ablution (*tayammum*), Shafiʿī jurists state that if a physician informs a patient there is a high probability that using water will result in a person getting ill (*al-ghālib ḥusūl al-maraḍ*), then it is forbidden for one to use water and he must perform dry ablution instead (al-Shirwānī 1972). Importantly this example does not indicate a moral obligation to seek medical treatment, rather the obligation is to avoid causing further harm.

In summary, the dominant position of the Shafiʿī school is that seeking medical treatment to be a recommended act that becomes obligatory when clinical efficacy is certain or highly probable (*ghalabat al-ẓann*) or if leaving off treatment results in certain death. Indeed the Shāfīʿ jurist-theologian Imam al-Ghazālī (d. 505/1111) held that seeking medical treatment is obligatory only when cure is certain and the proposed treatment is life-saving (Ghaly 2010; Albar 2007).

The Mālikī school of law

Although jurists of the Mālikī School have discussed the permissibility of medical treatments they have, in general, not detailed whether such treatments can be deemed mandatory. The prominent Mālikī jurist al-Dardīr (d. 1201/1786) in al-Sharḥ al-Ṣaghīr ʾilā Aqrab al-Masālik confirms the ruling of permissibility and only mentions obligation saying "seeking medical treatment is permissible. It may be obligatory…the treatment's benefit should be known through the science of medicine." (al-Dardīr and Ṣāwī 1972, vol. 4 p. 770). Unfortunately, al-Dardīr does not elaborate on when the general permissibility of seeking treatment becomes obligatory, and Aḥmad al-Ṣāwī in his commentary on the text does not offer any further comment. However other Mālikī jurists provide some insight in the assessment of obligation. They classify medical treatments into those whose efficacy medical experts are certain of, those with probable (*madhnūn*) clinical efficacy, and those treatments whose efficacy has not been established (*mawhūm*). The ethico-legal rulings pertaining to seeking medical treatment are made on the basis of the posited clinical efficacy of treatment, or on the certainty of harm without treatment. For example, Shaykh Muḥammad al-Khadīm offers that clinical treatment becomes obligatory when not doing so will have a (certain) fatal outcome (al-Khadīm 2011).

The Ḥanbalī school of law

Jurists of the Ḥanbalī school such as Ibn Mufliḥ (d. 763/1362) report the dominant position of the school being that seeking medical treatment is permissible but abstaining is superior. He states "seeking medical treatment is permissible, however not utilizing it is more meritorious. [Imam Aḥmad] unequivocally stated this. In al-Marwūdhī's transmission, [Imam Aḥmad] said, "Treatment is a dispensation. Not seeking out treatment is a degree higher than it" (Ibn Mufliḥ al-Maqdisī 1996, vol. 2 p. 333). Ḥanbalī jurists give preference to the reward for a person to patiently bear the harm caused by the illness by interpreting the Prophetic statement to seek out medical treatment as general advice (*irshad*) and not a moral directive. An earlier jurist, Ibn Qudāma al-Maqdīsī (d. 620/1223), also advances this position noting that where clinical efficacy is high and there are likely to be no detrimental side effects "[I hold that] seeking such treatment would be permissible (only)" (Ibn Qudāmah 2007, vol. 2 p. 52). Although, it is reported that the Ḥanbali jurist Ibn Taymiyya (d. 728/1328) did hold that medical treatment is obligated when cure is certain and the proposed treatment is life-saving (Albar 2007; Ghaly 2010), the prevailing position of the Ḥanbalī

school remains that seeking medical treatment is not an obligation.

In summary, the dominant position in the Ḥanafī, Malikī and Ḥanbalī schools is that seeking medical treatment is permissible but not obligatory, while Shafiʿī jurists hold seeking medical treatment to be a recommended act. All of the four schools of Sunni law regard that leaving medical treatment becomes sinful under exceptional circumstances and in the minority of cases. Ḥanafī jurists consider forgoing medical treatment even if this non-action results in death to not carry the weight of sin, while Shafiʿī and Malikī authorities suggest that Muslims would be considered to be sinning should they not seek medical treatment when the malady will cause death. The moral status elevation from a permitted or recommended act to a moral obligation appears to hinge on the certainty regarding a fatal outcome without treatment and/or certainty (or in the case of some Shafiʿī juridical opinions dominant probability) about the clinical efficacy of treatment in removing harm associated with the illness.

Before moving to discussing how these rulings can inform decision-making we would like to address several criticisms of the inherited Islamic ethico-legal canon that undergird the above judgements. An argument could be advanced that these classical positions on seeking medical treatment are outdated and no longer applicable. The nature of healthcare, as well as the types of and capacities of clinical intervention are vastly different today than they were at the time these dominant positions were crystallized. Consequently, the present state of technology and medicine is one that could not have been imagined or foreseen by classical jurists and a revision of their views is needed. Certainly such an argument has a measure of truth in it because every bioethical framework requires updating as human knowledge increases, and religious hermeneutics are often reimagined in the light of newer scientific understandings of the world. At the same time the juridical positions outlined above appear to account for the deliverables of medical science and thereby fortify themselves, at least partially, against this critique. The conditions set forth by schools that make clinical treatment mandatory require scientific evidence. For example, the Ḥanafī school requires certainty that the intervention will remove illness-related harms and while such certainty can reside in the patient more often than not empirical claims are the basis for such certainty. The Shafiʿī view follows the same pattern grounding a moral obligation to seek treatment in the assessment of clinical efficacy or knowledge that leaving off treatment would result in death. Here too clinical epidemiology and biostatics can deliver the answers. The Malikī position follows the same pattern as the Shafiʿī view. Only the Ḥanbalī view that medical treatment is never morally obligated distances itself from any consideration of the deliverables of medical science.

Modern fiqh academies seem to suffer from poorly accounting for modern scientific tools as well. For example, in 1992 the Organization of Islamic Cooperation sponsored Islamic Fiqh Academy, which includes Sunni jurists from all four schools of Islamic law as well as Shia jurists, met to revisit classical positions on the seeking healthcare. After deliberating over the state of biomedicine today and reviewing classical stances, the council issued a resolution that largely coheres with the more classical positions of the Shafiʿī and Malikī views. They state that seeking modern medicine is obligatory when neglecting treatment may result in (1) the person's death, (2) loss of an organ or disability, or (3) if the illness is contagious and a harm to others. (*Resolutions and Recommendations of the Council of the Islamic Fiqh Academy* 2000). This more modern view added categories (2) and (3) to the classical stances. Notably however the resolution does not mention how clinical efficacy informs moral obligation, and it is unclear whether the juridical council delved into discussions about the epistemology of medical science or how biostatistics is used to assess clinical efficacy (Ghaly 2010). Consequently this "updated" ruling may also insufficiently account for modern biomedicine. Nonetheless we believe revising the classical Islamic ethico-legal perspectives on the moral status of seeking medical treatment in light of the structure, epistemology, and tools of contemporary biomedicine is needed for constructing a holistic Islamic bioethics.

Similarly, one might argue that techno-scientific imaginary of, and as a result the ethico-legal constructs employed by, jurists of preceding epochs does not accurately for the modern science and thus the guidance offered by classical authorities imprecisely addresses the nuances of biomedicine today. This critique suggests that each epoch requires developing ethical constructs and frameworks that draw upon contemporary understandings of the world. Indeed as we come to understand the world around us more deeply Islamic constructs that rely upon social assessments, e.g. *maṣlaḥa* (public and private benefit/interest), or natural world processes, e.g. *istiḥālah* (transformation), may need to be revised so that they can be appropriately used in Islamic ethico-legal deliberation (Padela et al. 2014). While we are sympathetic to this argument, a comprehensive methodology for updating Islamic ethico-legal theories and constructs has yet to be developed and such an effort would require the massive mobilization of scholarly consensus in order to delineate what aspects of tradition are amenable to reimaging and which are not. Even if such a project were undertaken, the classical schools of law still offer, at a minimum, a credible starting-point for attending to the ethical challenges of modernity, and these opinions derived using traditional constructs and modes of reasoning maintain authoritative status within many institutions of religious learning today.

Relating the moral status of seeking medical care to the ethics of clinical intervention near the end-of-life

To illustrate how these rulings might inform deliberations about clinical interventions let us consider an intervention aimed at relieving pain. Islamic jurists would first address the question of whether a Muslim is obligated to seek medical care for pain, or conversely whether the action of not seeking pain treatment carries sin. Scriptural evidences and legal precedents would be sought to support arguments for or against the obligation. Since the question of whether a Muslim is obligated to seek medical treatment is closely related to the question of whether a Muslim is obligated to seek pain relief (and when pain relief requires clinical intervention it subsumes the question of seeking treatment), Islamic scriptures both suggest merit for an individual bearing pain but they also command the removal of pain (when seen as a harm). There are multiple traditions from the Prophet Muhammad, for example, that attach reward to enduring pain and relate his enduring of severe pain at the end of his life (Mattson 2002; al-Bukhari 2002; Hadith 4428, 5640–5642); further, the Qur'an recounts the story of the Prophet Ayub (Job) to note that his forbearance with harms from illness and his reliance upon God in the face of these was rewarded [21:83–84]. While such evidence funds the notion that forbearance with pain is rewarded and that forgoing therapy might be morally licit, the prophetic statement in Islam that there should be no harming or reciprocating of harm ("*la ḍarar wa la ḍirar*") informs a cardinal maxim of Islamic law that harm must be removed (Ibn Mājah Hadith 2341).

In light of the question of the moral status of seeking clinical intervention in the case of pain (relief), a moral obligation would ensure according to some schools when he two aforementioned conditions for obligation are met: (1) whether the patient might be expected to die from the pain; and, (2) whether there is sufficient research evidence that the proposed therapy will certainly or most probably remove the pain. Now since pain is not a physiological cause of death the first condition is not met. However, since the strength of evidence for the efficacy of different modalities of pain relief is variable, the general ruling remains an open question. In moving from the general ruling (*ḥukm*) to a specific verdict (*fatwa*) regarding a specific intervention, jurists would need to examine whether the proposed intervention carries any harms during the course of removing the harm of pain since both clinical treatment and Islamic law at their cores aim at removing harm. Such an assessment could be made in light of the higher objectives of Islamic law since actions that undermine the higher objectives of Islamic law are considered harmful. For example, clinical therapies that contain substances deemed ritually impure and/or prohibited for consumption, e.g. porcine-derived hormones or other medicines, might be deemed as threats to the objective of preserving religion, while treatments that render a patient unconscious might threaten both the preservation of intellect and the preservation of religion because the unconscious individual loses decisional capacity which is required for discharging religious obligations. Finally any other contextual factors relating to the patient and the proposed therapy would be considered prior to rendering a specific ethico-legal ruling. The results of this complex reasoning process might determine that an individual has a moral obligation to obtain the treatment, a moral obligation to refrain from treatment, or permissibility either way.

The critical point to note is that forgoing pain control interventions remains an ethically justifiable option in light of the general rulings about the moral status of seeking medical care. From the Ḥanbalī perspective, abstaining from intervention would be preferred, while the Ḥanafī view would be that certainty about pain relief is required for the moral obligation and that forgoing treatment when the efficacy of the treatment is uncertain is permitted. Since the Shafiʿī and Malikī stances base moral obligation on whether death would ensue without treatment, pain relief procedures from these two perspectives would appear to remain optional but not morally required since pain is not a proximate cause of death.

With respect to the ethico-legal argument for the non-obligated nature of clinical intervention near the end-of-life, a further comment regarding the conditions set forth by the jurists is necessary. Since some schools hold clinical treatment to be obligatory when non-treatment leads to death, and end-of-life clinical care necessarily deals with the impending death of a patient, one could argue that treatment at the end-of-life is obligatory. It is obligatory because impending death might be forestalled and/or the imminently dying state of the individual would be reversed. In the context of end-of-life care, however, it is important to recognize that many clinical interventions do not aim to avert death. Rather, interventions may be utilized for varied purposes including palliation or to maintain the viability of organs for possible donation. For example, an individual with oral cancer might seek the placement of a gastric feeding tube so that supplemental food and nutrition can be delivered through the tube. Such an intervention does not aim to change one's posited life expectancy nor would one be expected to die without it. In this case the juridical threshold of death without intervention would not be met, and obtaining the gastric feeding tube would remain within the realm of permitted actions. Additionally, even if a specific intervention aims at delaying death (setting aside

the theological discussions about human agency and its relationship to God's dominion over the specific moment of one's death), that intervention does not have to be indispensable to keeping them alive. Chemotherapy for chronic lymphocytic leukemia might represent such an intervention where treatment could increase life expectancy but at the same time a patient can live for many years without the treatment. Here too seeking therapy might not be morally obligated according to the juridical stances noted above and one would be permitted to forgo such therapeutics.

The classical juridical viewpoints described above also implicate clinical decision-making processes in several other ways. For one, these stances illustrate the importance of bringing together clinicians and religious scholars to advise patients and their surrogate decision-makers on courses of action. It is noteworthy that the schools of law that judged there to be an obligation to seek treatment did so provided that (1) the proposed treatment assuredly removes illness-related harms, or (2) that forgoing intervention results in death. These conditions necessarily implicate epidemiological and clinical data that would be out of the reach of most Islamic scholars. As such, joint consultations between clinicians and jurists are necessary to provide the nuanced guidance about the intended goals of, and the evidence supporting, proposed therapies and determining the moral valence attached to treatment that rides on the back of these data.

Aside from bringing to the forefront discussions of clinical efficacy and the expected outcomes without treatment, the preceding juridical discussions also subtly suggest that the end-goal of patient-doctor-religious scholar conversations should be the removal of illness-related harms. Some of the preceding Islamic authorities put forth that that the main purpose of medical treatment is the removal of harm *(al-ḍarar)* and harms can be categorized in many different ways. Islamic moral theologians define harm as something that results in a detriment (*al-mafsada*) *(Ibn Ḥajar al-Haytamī 2008, p. 516)*, and in turn a detriment refers to anything that undermines the higher objectives of Islamic law: the preservation of religion (*dīn*), life (*nafs*), intellect (*ʻaql*), lineage (*nasl*), and wealth (*māl*) *(al-Būṭī 2000; Auda 2008)*. While it is beyond the scope of this paper to discuss in detail, one could argue that the entire healthcare system and all medical practices seek to preserve or restore one or more of these five goods which constitute an Islamic conception of total human well-being. For example, reproductive health procedures and practices aim to protect the prospect of having a lineage, and mental health treatments can be viewed as attempting to preserve intellect.

At the same time, certain elements of medical practice might involve potential harms to one good while advantaging another. Receiving chemotherapy, for example, aims to protect life but risks reducing fertility and thereby is a detriment to lineage. As briefly noted above, Islamic jurists engage in a complex balancing act when determining the ethico-legal status of actions that promote one good while disturbing another because each of these goods have three subcategories (the essential—*ḍarurī*, the necessary—*ḥājī* and the enhancing—*taḥsinī*) as well as private and public dimensions; therefore there are multiple hierarchies to balance. Islamic law gives precedence to removing harms over procuring benefits, (Sachedina 2006) and Islamic notions of harm extend to the afterlife (Arozullah and Kholwadia 2013). Accordingly, in light of the juridical conditions informing the moral obligation to seek treatment and the overarching focus on removing harms, Islamically-inflected clinical-decision making would bring together patients, clinicians, and jurists to identify what harms a proposed treatment seeks to remove, to assess whether that harm leads to the preservation of the aforementioned five goods, to discern whether the proposed treatment entails harming in order to remove the disease-related harm, and to ascertain what evidence substantiates clinical efficacy for the proposed treatment removing the disease-related harm. By focusing on removing illness-related harms rather than recovery from illness, non-therapeutic, palliative treatments obtain religious utility because they deflect disease-related harms to human well-being.

The juridical stances above restrict the conditions under which medical care becomes obligatory and thereby, albeit somewhat counter-intuitively, open up the space for morally justifiable non-intervention and for non-religious values to hold sway in decision-making. In other words, by restricting the zone of obligation to act, the door is left open for there to be a variety of possible (and Islamically-permissible) courses of action, which include forgoing intervention. It is a commonplace (mis)perception that religious individuals tend to seek greater amounts of clinical interventions because of their religious values privilege all states of life and demand the usage of "God-given" technological capacities towards preserving life (Orr and Genesen 1997; Doig et al. 2006). This sort of ethical mandate, however, does not hold in a Sunni Islamic context because the moral obligation to seek medical treatment is narrowly circumscribed. Furthermore, the relatively high threshold for conditions to obligate clinical intervention empowers devout Muslim patients and their surrogate decision-makers to calibrate courses of treatment based on a wide range of personal values beyond the religious. Views on one's worth to society and family, tolerance for disability, fiscal responsibility, and many other values can all influence choices about whether to pursue an intervention after it is determined that the conditions that make

Islamic authorities consider intervention to be mandatory are not present.

Finally, the aforementioned ethico-legal stances admit a broader ontology of healing that widens the berth for justifiably forgoing clinical intervention. In their discussions about clinical efficacy, jurists (most prominently Ḥanafī authorities) asserted that theology demands that individuals can have their health restored without medical intervention. This notion is advanced on the basis of an Islamic ontology of healing that considers healing to occur by the leave of God, attaches healing qualities to prayer, and also maintains God's prerogative to heal without human intermediaries (Padela et al. 2012; Arozullah et al. 2015; Bakar 2008). Accordingly, forgoing clinical interventions is ethically justifiable in the face of their being alternate paths to healing.

Islamic conceptions of human dignity and inviolability and the ethics of end-of-life healthcare

Moving upstream from the classical Sunni ethico-legal assessments regarding seeking medical care, there are important theological concepts that can be used to support moral arguments for forgoing clinical interventions near the end-of-life: *karāmah* and *ḥurmah. Karāmah* and *ḥurmah,* often translated as dignity and inviolability respectively, are two closely related concepts sourced in the Qur'an and Sunnah that inform ethical thinking about the body and its care. In what follows we will briefly introduce the concepts and then detail how they might impact decisions about clinical interventions near the end-of-life.

Karāmah derives from an Arabic root that conveys the meanings of honor and generosity (Wehr et al. 1979). Multiple verses in the Qur'an and traditions from the Prophet Muhammad give shape to this Islamic analogue for human dignity. An Islamic conception of human dignity appears to reside between what Sulmasy terms "attributive" and "intrinsic" models (Sulmasy 2013, 2016). It is attributive in that dignity is conferred by God and is given value because of this choice favor, and it is intrinsic in so far as dignity inheres within humankind by the virtue of belonging to sort of thing humans are- a special type of God's creatures. The Qur'an stresses that God bestowed dignity to humankind stating "We have honoured (*karamna*) the sons of Adam… and conferred on them special favours, above a great part of our creation [17:70]" (Ali 1999) and it goes on to further stress the relationship between dignity and God's favor by declaring that "the most honoured of you in the sight of Allah is the most righteous of you [49:13] (Ali 1999)". Importantly Qur'anic commentators note that human dignity is a reflection of God's grace and that all of humanity share equally in this favor; that it is not gained through meritorious conduct, yet further closeness to God is obtained through human actions (Mattson 2002; Kamali 2002). The special dignified rank of humankind is further observed by the rhetorical strategies utilized by the Qur'an to describe the creation of the progenitor human, Adam. Several verses state that God fashioned the human and perfected his image and form [7:11, 40:64, 64:3, 95:4] and in one verse evokes the metaphor of God creating Adam by His hand [38:75] to denote God's care for humanity and the dignified existence bestowed to humankind. Another set of narrations relate that Adam was created in God's image, thereby signifying another level of honor to the human form. And is it on this basis that the Prophet Muhammad forbade disputants to strike one another in the face. (Mattson 2002; 20652: Commentary on the hadeeth, "Allaah created Adam in His image"; Khaṭīb al-Tibrīzī and Robson 1981; Sahih Muslim Hadith 2612 e, 2841)

Ḥurmah is closely related *karāmah,* indeed one may argue that *ḥurmah* emerges from *karāmah,* and is derived from an Arabic root that carries the meaning of sacredness and prohibition (Wehr et al. 1979). The term connotes human sanctity, inviolability and sacredness as gleaned from its usage throughout the Islamic scriptures. Often the term is used to ground negative rights. For example the Qur'an states "Nor take life—which Allah has made sacred (*ḥarramullah*)—except for just cause [17:33]" (Ali 1999). This inviolability of the human extends to his property and honor as the Prophet Muhammad declared to his followers during his final sermon at the time of Hajj within the sacred precincts of Mecca "Verily your blood, your property and your honour are as sacred and inviolable (*ḥarām*) as the sanctity (*ḥurmah*) of this day of yours, in this month of yours and in this town of yours.." (al-Nawawī Hadith 1524). Indeed the inviolability of the human body extends beyond death as another Prophetic narration reads "the dignity (*ḥurmah*) of a deceased person is the same as if he or she were alive" (Kamali 2003). Accordingly, the Prophet rebuked a careless grave digger by noting that breaking the bones of the dead is akin to breaking bones of the living (Qasmi; Sunnah.com).

Aside from the rulings mentioned by the Prophet as noted above the concepts of *karāmah* and *ḥurmah* serve as the foundation of multiple ethico-legal injunctions. For example prominent jurists, notably representing the Ḥanafī school of law, argue that Muslims are duty-bound to protect the integrals of human life irrespective of an individual's creed. (Kamali) Juridical authorities also remark that the sanctity of human life extends to the body parts such that disregarding the sanctity of one part of the human body is akin to disregarding the sanctity of human

life itself.(Krawietz 2003) Indeed *karāmah* and *ḥurmah* are reflected into Islamic rulings that prohibit the mutilation of the body and disturbing it post-mortem except without extenuating legal causes (Qasmi; Krawietz 2003).

So how might these concepts inform decisions about clinical interventions near the end-of-life? *Karāmah* in so far as it attaches honor to the human form, and of *ḥurmah* as it considers the human body sacred, give pause to the disruption of bodily integrity and alteration of its appearance. Many types of clinical interventions, by their nature, intrude upon bodily integrity and high-stakes interventions might require advanced monitoring and supportive care mechanisms that also require instruments be placed on/in patient's bodies. Hence decisions about courses of medical care, particularly near the end-of-life, must balance the posited benefits attached to clinical procedures against the threats to *karāmah* and *ḥurmah* via the violation of bodily integrity and appearance. The notion of *ḥurmah* as it relates to maintain bodily integrity is so critically important to Islamic law that some jurists justify their prohibition of organ transplantation on the basis of it. They hold that the removal of an organ from a body compromises *ḥurmah* and cannot be justified because the surgery brings no benefit to the donor and thus is akin to mutilation. Furthermore these jurists consider that *karāmah* makes for the "non-usability of human organs [in another body]."(Qasmi) The notion of human dignity was also advanced by Islamic jurists to prohibit organ trade, as it renders the human body as a mere commodity, and undergirds Islamic bioethical rulings about the necessity of informed consent in medical treatment and research as dignity demands freedom of choice (Alahmad 2016). Accordingly, healthcare delivery at the end-of-life that accounts for an Islamic conception of *ḥurmah* would adopt a cautious approach to clinical intervention for "the protection of the bodily integrity and the respectful treatment (*takrim)*of the human body do not merely serve its material quality but acknowledge the superior status of the human being" (Krawietz 2003, p. 197). Harkening back to our discussion about the limited conditions under which clinical intervention is morally obligated by Islam, the theological constructs of *karāmah* and *ḥurmah,* provide further support for ethically-justifiable non-intervention where interventions have marginal utility and cause great disruption to the body.

The concept of *karāmah* can inform an Islamic ethics of care for the dying in another way; the notion underscores a need to preserve the God-human relationship while delivering healthcare. Since human dignity is conferred by God and nurtured by God-consciousness, healthcare providers should facilitate worship activities that are central to a Muslim's relationship with God and should provide spiritual support through referrals to Muslim chaplains, imams and other religious leaders as necessary. Bearing in mind that the patient is a dignified creature who has a relationship with God might help healthcare providers to see past the disease which disrupts human physiology and tend to the human spirit that is a receptacle for *karāmah*. For Muslims dignity is experienced by recognizing one's dependence upon God and acknowledging that illness, health and cure all come from Him, hence illness does not lessen a patient's dignity rather may enhance one's experience of it (Mattson 2002). Furthermore, since consciousness is considered as a condition for worship as well as for spiritual practices, clinical interventions might be aimed at preserving the cognitive and intellectual faculties in so far as possible such that these religious activities can be maintained. Thus attending to *karāmah* while delivering healthcare at the end-of-life entails attending to the spiritual aspects of the patient's well-being.

In summary the construct of *karāmah* brings the spiritual side of the patient into relief suggesting that spiritual well-being should be one of the aims of healthcare delivery, while both *karāmah* and *ḥurmah* suggest that the potential for disrupting the sanctity and inviolability of the body should be considered whilst assessing the benefits and harms of clinical interventions. These concepts are particularly important to consider (and revisit) as patients may end up with ever-diminishing capacities for religious activities and may require ever-increasing amounts of diagnostic and monitoring instruments and life sustaining measures that are placed on/in their bodies as end-of-life healthcare proceeds.

Searching for a holistic Islamic ethics for healthcare at the end-of-life

As doctoring has come to involve an increasing use of technology and greater amounts of clinical intervention, many have voiced concern over the erosion of the humanism in contemporary medical practice. The decline of humanistic practice is particularly noticeable in end-of-life care and is contributed to by a variety of social practices and structures within contemporary healthcare (Bishop 2011; Dugdale 2010, 2015). In particular, healthcare has become compartmentalized as general and specialist physicians, social workers, and chaplains all minister to different aspects of the patient and all too often take the parts for the whole and overlook the linkages between the patient's psychosocial circumstances, spiritual outlooks, and healthcare choices. Additionally, public discourse on healthcare often portrays physicians as "men against death" and highlights the technological marvels and powers of their practice, consequently making conversations about forgoing clinical interventions seem oddly

dissonant to social norms; this can leave patients and providers ill-equipped to discuss and prepare for death (De Kruif 1932; Gordon 2015). To be sure, palliative care as a specialty has secured a room within the house of medicine and seeks to revive conversations about living well while in the process of dying. However, some wonder whether this specialty represents another attempt by medicine to "fix" the "problem" of dying, and whether the noble motivation to help people flourish while dying is obscured by practices such as terminal sedation and "aid in dying" (or assisted suicide) that actually cause death (Bishop 2011; Dugdale 2014; Snyder et al. 2001).

Religious traditions might help modern medicine address these challenges by providing a moral vision for the practice of medicine, or at the very least, draw attention to the (humanistic) values that are at stake in the debates about what medicine should be about and what clinicians should offer. In a sense all of the debates about end-of-life care boil down to two critical questions: (1) what physiological/psychological states constitute a life worth living?; and, (ii) are healthcare providers morally obliged to use any and all means at their disposal to help patients maintain or to restore a "life worth living"? For example, some individuals may believe that a life of pain or psychological distress is not worth living and thus desire a painless and unconscious decline into death. At the same time, some clinicians might hold that every state of human life is worth living and preserving and/or that their professional ethics demands that they do not participate in assisted death. Successfully navigating these potentially conflicting views about patient rights and physician duties has wide-ranging implications for the social ordering of healthcare delivery and the public's expectations of the healthcare system. As we deliberate over how best to attend to care of the dying, Islamic bioethical perspectives, given the more than 1.5 billion Muslims and multiple Muslim-majority nations around the globe, are important to develop as they may offer practical guidance to a large portion of humanity (Mapping the Global Muslim Population 2009).

As of yet, however, the nascent academic field of Islamic bioethics does not provide answers to the two aforementioned questions in a systematic or holistic way. To begin with, what is a life worth living according to Islam? As discussed above, human life is considered sacred and inviolable by Islam and the human being is honored and dignified. Given the ability of modern medicine to preserve physiological states of varying degrees with or without affective dimensions of the human, conversations about how these Islamic teachings and theological constructs are reflected in quality-of-life metrics and goals of care near the end-of-life are still in an emerging state (Padela and Mohiuddin 2015a, b). While there are multiple theological and ethico-legal resources to help identify the states of life medical therapeutics should aim to preserve various Islamic bioethical authorities appear to have disconnected views about these matters. Islamic jurists differ on whether abortion is permissible and what conditions justify abortion, and they also disagree about the physiological states that permit withdrawal of life support (Moazam 2005; Brockopp 2008; Sachedina; Qasmi; Krawietz 2003; Padela et al. 2013; Padela and Basser 2012; Yacoub 2001; Atighetchi 2007; Ebrahim 1998, 2008). While ethico-legal pluralism is a valued trait of the Islamic ethico-legal tradition, some of these verdicts are not only contradictory but also overlook considerations about medical practice that render them ineffectual (Padela et al. 2011). One could argue that judgements about when a certain type of life need not be brought into this world and when a certain type of life can be allowed to expire are two sides of the same coin as they attend to a moral vision for what constitutes a life worth living (or a life worth preserving medically). As such, a robust consensus-based theological conception of a life worth preserving in the context of modern medicine (or several such conceptions) would provide a tangible end goal for clinical interventions at the borders of life and death. Additionally, such constructs would provide jurists with an ideal that can be looked to as they mine the sources of Islamic ethics and law to pen rulings that assess the permissibility of intervention and non-intervention at the boundaries of life.

Some scholars suggest that instead of looking to theology, theorization at the level of Islamic ethico-legal genre of the higher objectives of Islamic law, *maqāsid al-shariah*, might provide the end goals needed to delineate ethical healthcare practices. For example,one could argue that the since preservation of life is one of the undisputed higher objectives of Islamic law, and many jurist-theologians have described its essential (*ḍarurī*), necessary (*ḥājī*) and embellishing (*taḥsinī)* aspects, these classifications can be used to develop a bioethical framework for end-of-life healthcare (Saifuddeen et al. 2014). We agree that this strategy has merit, yet feel that theology provides greater space for conceptualization than the *maqāsid* genre does. While a locus of much scholarly attention, scholars continue to debate whether the *maqāsid* are open to revision, whether new *maqāsid* are needed for the modern area, and how reasoning should proceed from *maqāsid* to ethico-legal ruling. While theology is not without its controversy, we believe that moving upstream from ethics and law affords freedom to theorize.

Islamic jurists are keen to limit the zones of obligation (and non-obligation) for clinicians with respect to the question of whether healthcare providers are morally obliged to use any and all means at their disposal to help patients maintain or to restore the state of "a life worth living." As noted above, Sunni authorities considered

scriptural evidence as they mapped out the moral status of seeking medical care, and they took care not to attach sin to forgoing treatment by determining this action to be generally permitted. Similarly, jurists have been careful in judging that clinicians are not obligated to provide clinical treatments when such treatments are not efficacious or otherwise not expected to yield positive outcomes. For example, multiple jurists and juridical bodies permit the withdrawal of life support when patients are not expected to recover perception, are terminally ill, or are declared brain dead. These rulings absolve clinicians from the obligation to maintain life support in the face of a vague conception of medical futility. (Mohiuddin 2012; Albar and Chamsi-Pasha 2015). While Islamic jurists tend to focus on demarcating the line between *ḥalāl* and *ḥarām* (the question of "can I do such and such?"), we believe that theological conceptualization should accompany these ethico-legal deliberations and would attend to the "should I?" question. In other words, a clinician may not be obligated to withdraw life support from a patient in a minimally conscious state but should life support be maintained? While Islamic law does categorize some actions both as recommended (*mandūb* or *mustaḥab*) and as discouraged (*makrūḥ*) and thus can involve the question as to whether one ought to do certain actions, in our reading these categorizations rarely appear in extant Islamic bioethical verdicts. On the other hand, a theological conceptualization of the life worth living (or preserving through medical intervention) that is borne in mind while making ethico-legal assessments would assist all parties in making decisions about courses of clinical intervention and the withholding or withdrawal of advanced life support.

Furthermore, while Islamic ethico-legal discourse runs rife with discussions on the permissibility of actions, other genres of Islamic ethical reflection address how best to act. For example, the corpus of advice (*adab)* literature focuses on moral formation by inculcating the practices of virtues such that an inner disposition towards the virtuous and meritorious actions results (Sartell and Padela 2015). In addition to *adab* literature, the Islamic tradition also upholds spiritual practices which cultivate God-consciousness and thereby motivate not only acting in accord with the Islamic law but also performing in the way most pleasing to God. A holistic Islamic bioethics should attend to these genres of Islamic ethical reflection that focus on individual moral formation because "being good" coincides with "producing good" (Sartell and Padela 2015). It is obvious that for a holistic ethics of care for the dying, the patient's surrogate decision-makers and providers would benefit from knowledge about how best to accompany the dying and practices that engender such comportments.

While Islamic theological resources, ethico-legal genres, and spiritual practices exist, what is needed, at least with respect to Islamic ethical reflection about medicine and healthcare, is a way for bringing all of these resources together to offer a holistic, Islamic vision for the practices and uses of medicine. Theological markers of a life worth living and constructs of human dignity and inviolability need to be both foregrounded for Islamic bioethical decision-making, and also on the back end to be utilized for calibrating rulings about the permissibility of clinical procedures. At the same time, an Islamic ontology of healing that delineates the roles of patients and providers in attracting healing from God can not only serve as a further check on juridical rulings (as can be seen from the ethico-legal discussions about permissibility of forgoing medical treatments above), but also can help to inform advice literature and spiritual practices that support the moral formation of patients, clinicians, and other healthcare actors. Indeed, classical manuals and practices that assist with moral formation might require updating so that they can address the spiritual maladies of a world that is swayed by the power of biomedicine yet persists to have a social ordering of medicine that allows for patient-level health inequities and leaves clinicians with profound questions about the moral worth of their profession. Ultimately, addressing the character and spiritual development of the agents of action, in this case the healthcare actors, is integral to fulfilling the aims of Islamic law—for ethico-legal rulings remain theoretical until embodied within human behaviors. A holistic Islamic ethics for healthcare at the end-of-life requires bringing together physicians, patients, Islamic jurists and theologians, social scientists, and allied health professionals and stakeholders in a shared enterprise. This enterprise would first focus on generating a more accurate and complete understanding of the ethical problem-space within contemporary healthcare and then seek to generate a conceptual lexicon that allows for these experts to engage in cross-talk to appropriately deploy the methods of each other's fields in deriving Islamic bioethical guidelines and manuals. Such efforts are in a nascent phase and it is our hope that the rudimentary outline of a methodology that starts with theology and then moves to jurisprudence and brings in moral formation as a complement serves to bolster these fledgling efforts.

Conclusion

In this paper we have demonstrated how classical Sunni legal stances on the moral status of seeking medical care, and the Islamic concepts of human dignity and inviolability, allow for ethically justifying the forgoing of clinical intervention particularly near the end-of-life. Hence while the dominant opinions within the Sunni schools of law suggest that we *can* intervene they, in general, do not support the

claim that we *must*. While research suggests that individuals with religiosity utilize greater healthcare resources at the end-of-life; that some communities may not accept the withdrawal or withholding of end-of-life care treatments on account of their religious values, and that patients receiving spiritual support from religious communities are more likely to receive aggressive clinical treatments at near the end-of-life, in our view Islamic perspectives might provide Sunni Muslim patients and families with ethical grounds for less aggressive interventions.(Inthorn et al. 2015; Shinall et al. 2014; Shinall and Guillamondegui 2015; Balboni et al. 2013) To be sure the legal rulings about the moral status of seeking medical treatment vary somewhat across the 4 Sunni schools of law, have areas of ambiguity, and may not fully account for the nature and epistemic bases of modern biomedicine. Consequently, jurists and juridical councils need to reexamine classical formulae and provide revisions that take into account the deliverables of modern biomedicine and the current social realities of healthcare more fully. Alongside this re-examination we suggest that Islamic scholars develop a holistic, theologically-grounded, Islamic bioethics that brings together theology, law and spiritual formation so that both the moral status of actions undertaken by patients, clinicians, and other healthcare actors, and the moral formation of the actor him(her)self is attended to.

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