Maqāṣidī Models for an "Islamic" Medical Ethics: Problem-Solving or Confusing at the Bedside?

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Abstract

The *maqāṣid al-shari'ah* are championed as tools to address contemporary societal issues. Indeed, it is argued that *maqāṣid*-based solutions to present-day economic, political, and cultural challenges authentically bridge the moral vision of Islam with modernity. Advocates also stress that *maqāṣidī* models overcome shortcomings within *fiqh*-based strategies by bypassing their over-reliance on scriptural and legal hermeneutics, their dated views on social life, and their analytic focus on individual

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action. Herein I critically analyze efforts to bring *maqāṣidī* thinking to the clinical bedside. Specifically, I describe how leading thinkers such as Profs. Gamal Eldin Attia, Tariq Ramadan, Omar Hasan Kasule, and others build *maqāṣid* frameworks for medical ethics by expanding upon Imam Abū Ishāq al-Shāṭibī's *maqāṣid al-sharīʿah* theory. I categorize these varied approaches into three types (field-based redefinition, conceptual extension, and text-based postulation) and detail how each sets up a specific method of medical ethics deliberation. Moving from the theoretical to the practical, I use a test case, a 19-weeks pregnant "brain dead" Muslim woman, to ascertain the goals of care and the respective moral responsibilities of her husband and the treating Muslim clinician using the three models. Next, I discuss the merits and pitfalls of each proposed solution and comment on how these match up with extant *fiqh*. To close the paper, I comment on the place of *maqāṣidī* thinking in Muslim engagement with contemporary biomedicine, contending that such frameworks are presently too under-developed for medical ethics deliberation at the bedside. Indeed, without further elaboration from theorists, appeal to the *maqāṣid* in medical ethics deliberation may provide clinicians, patients, and other stakeholders with ambiguous, incomplete, impractical, or otherwise problematic answers.

Introduction

As biotechnological advancements increase humankind's ability to rejuvenate human bodies, healthcare stakeholders look to bioethicists, religious leaders, and policy analysts for guidance about the right ordering of biomedicine. Indeed as biomedical capabilities grow, clinicians, patients, and policy-makers grapple with questions about whether and how we ought to apply novel technologies and therapeutics at the bedside. As the religion of approximately a quarter of the world's population,[1] Islamic perspectives on these pressing bioethical issues are increasingly sought by Muslim stakeholders; in turn, religious leaders,

clinicians, and academicians strive to delineate what the intellectual tradition can offer to bioethics discourses.[2]

Recent years have witnessed an ever-increasing number of conferences and symposia, journal articles, special volumes, and press articles related to Islamic bioethics.[3] Despite these efforts, however, the content and contours of the field remain obscure. Questions about the grounding for Islamic content and the reasoning exercises that must be undertaken to deliver bioethical guidance remain unsettled. End-users are thus left with impractical and partial guidance.[4]

Given this general state of affairs, several Muslim thinkers advocate approaches to Islamic ethics based on the higher objectives of Islamic law, the *maqāṣid al-sharīʿah*. Different rationales for why frameworks built upon the *maqāṣid al-sharīʿah* may better furnish Islamic medical ethics guidelines than *fiqh* (Islamic jurisprudence) and *adab* (virtue ethics)-based models are advanced.[5] For one, it is argued that *maqāṣid al-sharīʿah* frameworks better account for changing societal conditions and new scientific knowledge than traditional methods of deriving Islamic law.[6] Said more plainly, advocates contend that because the theoretical concepts and applied constructs of *maqāṣid al-sharīʿah* are intimately linked to rational proofs, they better accommodate social and natural scientific data than the scripture-heavy reasoning methods of *fiqh*. Secondly, when decoupled from scriptural hermeneutics and advanced legal reasoning methods, *maqāṣid*-based ethical frameworks are more useful for practical decision-making by individuals on the ground. Moreover, this feature makes the *maqāṣid* particularly amenable to interfaith dialogue and public deliberation. Finally, the notion that *maqāṣid*-based frameworks represent the broader "spirit" of the Islamic revelation and, as such, are more appropriate grounds than legal injunctions and constructs for developing field-specific moral philosophies and ethical frameworks is also advanced.[7] Consequently, *maqāṣid al-sharīʿah* frameworks are seen as both close to the human mind and to the Divine intent, and thus a firm foundation upon which to build out an Islamic bioethical theory.

While quite a few scholars are using *maqāṣid al-sharīʿah* frameworks for medical ethics deliberation,[8] little attention has been paid to

analyzing these varied models. This paper fills this scholarly lacuna by critically examining operationalizations of *maqāṣid* for clinical medical ethics. I will begin by describing leading contemporary *maqāṣid* theories and how these theories are applied to medical ethics. Next, I will use a hypothetical case involving a Muslim woman declared "brain dead"[9] at 19 weeks gestation to compare the ethical guidance based on each of these approaches while also commenting on the commensurability of each solution with established *fiqh*. I will close the paper with a general reflection on the merits and pitfalls of *maqāṣid*-based engagement with contemporary biomedicine.

The *Maqāṣid al-sharīʿah*

Before delving into the intersection of *maqāṣid* and medical ethics, a general conceptual overview of the *maqāṣid al-sharīʿah* is warranted. Moreover, since leading Muslim thinkers tackle questions of medical ethics using frameworks built upon the *maqāṣid al-sharīʿah* theory of Abū Ishāq al-Shāṭibī (d. 790 AH/1388 CE), a 14th-century Sunni legal theorist and Malikī jurist, his model warrants a brief introduction as well.

What are the Maqāṣid al-Sharīʿah?

The term *maqāṣid al-sharīʿah*, commonly translated as the higher objectives of Islamic law, refers to the purposes and intents of the Lawgiver in legislating. Islamic legists hold that God, in general, legislates to procure benefit and forestall harm from humankind in this world and the hereafter.[10] Thus, every Islamic ruling reflects specific human interests, and protecting those interests is the Lawgiver's intent. Based on this relationship between Islamic law, divine intents, and human interests, legists seek to discern the rationale behind injunctions in the Qur'an and Sunnah. Some theorists assert that Islamic law has a core set of higher objectives around which deliberative and legislative frameworks can be built. These core objectives are termed the *maqāṣid al-sharīʿah,* and the theoretical frameworks of the *maqāṣid al-sharīʿah* discern how core human interests are advanced or threatened in a given situation.

As referenced above, the premise that there are rationales behind scriptural commands is central to Islamic ethico-legal theory because it allows for extending revelatory norms to cover situations not directly addressed by scripture. For example, the traditional method of deriving Islamic legal norms, *uṣūl al-fiqh,* terms the process of identifying the *ratio legis* as *taʿlīl,* and legists utilize, in variable fashion, analogical reasoning, *qiyās,* to extend scripture and precedent-based rulings to new matters.[11] *Maqāṣid al-sharīʿah* theorists extend this idea to promote universal overarching rationales (higher objectives) that undergird the totality of Islamic law. Illustratively, the father-figure of the science of *maqāṣid al-sharīʿah,* Abū Ishāq al-Shāṭibī, identified five essential, *ḍarūrī,* higher objectives: the preservation of religion (*dīn*), human life (*nafs*), progeny (*naṣl*), material wealth (*māl*), and intellect (*ʿaql*).[12]

Once identified, a catalog of higher objectives may be used in various ways. *Maqāṣid* models can be used as an adjunct to traditional *uṣūl al-fiqh.* For example, Islamic scholars may derive several rulings based on *uṣūl al-fiqh* methods and subsequently prioritize among these based on the extent to which one or another preserves the *maqāṣid* better. *Maqāṣid al-sharīʿah* models can also complement *uṣūl al-fiqh* by serving as grounds for Islamic laws where scripture is silent.[13] Taking this approach a step further, and with considerable controversy, the *maqāṣid al-sharīʿah* may be used independently as the primary grounds for Islamic ethico-legal rulings. Each of these strategies continues to be developed and debated by Islamic scholars. As will be seen below, those scholars engaging bioethical issues using the *maqāṣid* typically use it as an independent source of morality.

Core aspects of al-Shāṭibī's Maqāṣid al-Sharīʿah *theory*

Over the centuries, many scholars have articulated theories of the *maqāṣid al-sharīʿah.* Abū Ishāq al-Shāṭibī, a 14th-century scholar of Malikī law, is often credited with being the first to develop a comprehensive legal theory of the *maqāṣid,* and his model continues to inform all subsequent expositions. He arrived at the core overarching *maqāṣid*

via an inductive reading of the Qur'an and Sunnah. He notes that "such an indicative reading, since it looks to the overall, inner spirit of the Law rather than just its outward details or particulars, cannot be carried out on the basis of single text of piece of evidence, rather it requires the marshalling of numerous texts which embody a variety of objectives and which, when added one to another, yield a single conclusion upon which they all agree."[14] Resultantly, al-Shāṭibī's classifies three types of *maqāṣid*—*ḍarūrī*, *ḥājī*, and *taḥsīnī* (essential, necessary, and enhancing, respectively)—in descending order of importance. Conceptually, the *ḍarūrī* or essential *maqāṣid* "seek to establish interests of the *dīn* [literally religion but connotes the hereafter in this usage], and the *dunya* [refers to the world but in this case means this life]...their absence leads to corruption and trials as well as loss of life," and also leads to "loss of success and blessings" in the hereafter.[15] The *ḥājī* or necessary *maqāṣid* bring facility to, and remove obstacles from, human life. The *taḥsīnī* or enhancing objectives, on the other hand, represent acquiring good manners and avoiding ill ones such that human behaviors are perfected.[16] The relationship between the three categories is one where the *ḥājī* supplement the *ḍarūrī*, while the *taḥsīnī* complement the *ḥājī*. Furthermore, while trying to secure the objectives, a hierarchal order is to be maintained such that the *ḍarūrī* must not be comprised while securing the *ḥājī* or *taḥsīnī*.

To illustrate this hierarchy, let us consider the provision of food as a moral obligation that issues forth from the *ḍarūrī* objective of preserving life. Consequently, a *ḥājī* objective might be ensuring food is nutritiously balanced, and a *taḥsīnī* objective might be to assure that food is presented and eaten with decorum. When the food is scarce, concerns about the nutritious value of foodstuffs and table etiquette do not supersede the moral obligation to ward off starvation through sustenance.

Al-Shāṭibī further identifies five essential *maqāṣid*: the preservation of religion (*dīn*), human life (*nafs*), progeny (*naṣl*), material wealth (*māl*), and intellect (*ʿaql*). He notes that *ḥājī* and *taḥsīnī maqāṣid* must be identified either by scriptural inference or by independent reasoning and are always contextual. He circumscribes the ambit for human reason to specify *maqāṣid* to cases where there is no scriptural evidence

to substantiate or negate the human interest in question. Notably, these secondary objectives are valid so long as they strengthen, reinforce, and support the overarching essential *maqāṣid*.[17] Al-Shāṭibī considers such ratiocination to cohere with the methodological device of *maṣlaḥa mursala*. He states, "(when the Lawgiver is silent) we have recourse to an examination of the different meanings of *maṣāliḥ* (human interests). Anything in which we discover an interest, acting upon *maṣāliḥ mursala*, we accept, and anything in which we find an injury, again acting on the *maṣāliḥ*, we reject."[18]

Before discussing contemporary *maqāṣid* frameworks and their relevance to medical ethics, a few more remarks regarding al-Shāṭibī's hierarchical schema are necessary. First, it is important to note that while the five essentials are an interdependent unit, al-Shāṭibī judges the interest of religion to be the most important moral value. He asserts that if religion is not preserved, then the "affairs of the next world cannot survive," and the ultimate purpose of creation is thwarted.[19] He does, however, acknowledge that if human life is lost, then there is no moral subject, and if reason is missing, religious belief will become non-existent. Similarly, if the capacity for progeny is totally lost, then the survival of life is at-risk, and without preservation of material wealth, "life cannot be maintained."[20] Consequently, the preservation of material wealth and the capacity for progeny serve the preservation of life. In contrast, the preservation of the intellect and of life are subordinate to the ultimate interest: religion. After the *maqṣid* of preservation of religion, al-Shāṭibī holds that the preservation of life is the most important *maqṣid*.[21] Concerning the order of priority among the preservation of progeny (*naṣl*), material wealth (*māl*), and intellect (*ʿaql*), it is unclear whether al-Shāṭibī maintained a consistent hierarchy.[22]

Maqāṣid Frameworks and their Engagement with Medical Ethics

As Muslim thinkers develop *maqāṣid al-sharīʿah* frameworks, the unsettled state of Islamic medical ethics has made it a particularly ripe site to test out various deliberative models. Indeed, there is a small but growing

literature at the interface of medical ethics and *maqāṣid al-sharīʿah,*[23] and medical ethics training programs in the Muslim world have begun to incorporate teaching on the *maqāṣid.*[24] In what follows, I describe three different ways in which al-Shāṭibī's theoretical model has been expanded for use in medical ethics deliberation.[25] Notably, scholars' approaches to reformulating al-Shāṭibī's model were not made with biomedicine as the dialectical partner. Instead, the theorists' underlying motivation was to address design broadly applicable *maqāṣid al-sharīʿah* frameworks. Accordingly, the approaches and techniques I describe below are general attempts to build out *maqāṣid* theories.[26]

Approach 1: Field-based Redefinition

This approach circumscribes itself within al-Shāṭibī's framework and reimagines the five *ḍarūrī maqāṣid* in light of contemporary healthcare. Prof. Omar Hasan Kasule, a medical scientist and bioethicist, is the leading proponent of this approach, stating that the traditional five essential *maqāṣid* provide an all-encompassing "Islamic theory of [medical] ethics."[27] Consequently, "for a medical issue to be considered ethical it must fulfill or not violate one of more of the five purposes (*maqāṣid*)."[28] In this way, the five essential *maqāṣid* function as meta-level principles undergirding an Islamic medical ethics theory.

To specify the objectives of preservation of religion (*dīn*), life (*nafs*), progeny (*naṣl*), wealth (*māl*), and intellect (*ʿaql*), surface-level theorization is undertaken to redefine these human interests. The human interests come to be grounded in biomedical understandings, and medical treatment's moral purview becomes promoting these interests as far as possible. Subsequently, the medical ethics model built upon field-based redefinition transforms health into the ultimate human interest and refashions *maqāṣid* into hierarchical ethical principles servicing health.

Accordingly, the concept of *dīn* comes to represent worship, *ʿibadāh,* in a broad sense incorporating both prayer and good deeds.[29] Healthcare is envisaged to preserve this interest by "protecting and promoting good health so that the worshipper will have the energy" to pray and perform meritorious deeds.[30] Similarly, treating mental disorders assists in

preserving *dīn* (in this theory, worship) because "balanced mental health" is integral to prayer and creedal affirmation.[31] Human life, *nafs,* is seen as a self-explanatory interest preserved by preventing and treating disease, ensuring proper body nutrition, and applying therapies that maintain a high quality of life. The human interest of progeny is correlated with procreative capacity. Consequently, healthcare must protect this value by treating infertility and "making sure that children are well-cared for so that they grow into healthy adults who can bear children."[32] The human interest of intellect is reformulated as mental health, and medical care preserves this interest by treating physical illnesses that contribute to mental stress, psychoses, and drug addiction. Finally, wealth is redefined as societal wealth, and healthcare assists citizens to be financially productive by helping to maintain sound bodies and minds.[33]

While the "protection of life is the primary purpose of medicine," this model holds that healthcare intersects with all five essential interests.[34] Accordingly, a hierarchical order among the interests is maintained such that the preservation of religion (worship) takes precedence over all other interests, the preservation of human life comes second, and the preservation of progeny (procreative capacity), (societal) wealth, and mind (mental health) follow in that order.[35] According to its proponents, this hierarchy "allows for the resolution of conflicting interests," as higher-order interests are privileged over lower-order ones during the medical ethics deliberation.[36] Kasule terms this type of moral reasoning *ijtihād maqāṣidī* and popularizes the approach in medical school curricula around the Muslim world.[37]

Several other Muslim thinkers align with Kasule's approach. Shaikh Mohd Saifuddeen, a scholar in the history and philosophy of science, also advocates *field-based redefinition* and its associated medical ethics deliberation model. Along with other colleagues, he writes that al-Shāṭibī's essential human interests must be "reinterpreted...in accordance with contemporary contexts" by considering contemporary harms and benefits within society and of healthcare technologies.[38] While he agrees with much of Kasule's reconstructions of human interests, he refashions the interest of wealth (*māl*) as property, including intellectual property. Furthermore, he holds that the preservation of intellect ranks above

the preservation of progeny and property,[39] and protecting human life takes precedence over preserving religion.[40] Somewhat confusingly, he also states that should a biotechnological application put any of the five essential interests at risk, it should be deemed impermissible from an Islamic standpoint, suggesting that the five interests are not hierarchical but should instead be considered be treated as a group.[41] Abul Fadl Mohsin Ebrahim, an Islamic studies expert trained both in seminary and university settings and a thought leader in Islamic medical jurisprudence, also finds value in Kasule's approach. For example, he states that the preservation of *nafs* includes protection of health, and agrees with expanding *ʿaql* to include mental health.[42] Bouhedda Ghalia, another Islamic studies expert, takes a similar approach transforming the preservation of *nafs* into the protection of the human body.[43] Dr. Musa Mohd Nordin, a clinician and executive leader in the Federation of Islamic Medical Associations, also follows Kasule's approach by refashioning all the essential interests in light of healthcare.[44]

A few examples will aid the reader in understanding how this framework is applied to medical ethics. For instance, in the case where one spouse has AIDS, it is judged permissible for the spouses to separate in order "to prevent the spread of infection" because the preservation of life (*nafs*) is of higher priority than preserving procreative capacity (the refashioned construct of *naṣl*).[45] At the same time, permanent sterilization is prohibited because it contradicts the preservation of procreative capacity, and using reproductive cloning violates the preservation of religion, for it disturbs God's natural order.[46] Concerning cosmetic surgery, it is considered valid "if carried out for beautification in order to find a marriage partner" because it coheres with the duty to preserve *naṣl*. Yet, if the surgery is too "expensive," the preservation of wealth is at-risk.[47] Such reasoning exercises are complementary to Beauchamp and Childress' four principal approach to medical ethics deliberation in Saifuddeen's view[48] and to *uṣūl al-fiqh* according to Ebrahim.[49]

As an expanded version of the aforementioned deliberative model, Saifuddeen and his colleagues, Abdul Halim Ibrahim and Noor Naemah Abdul Rahman, also advocate another process. They propose that three aspects of any bioethical issue must be examined, the intent behind using

a certain therapy or technology, the particulars of the specific technology or technique utilized, and the end goal sought. These dimensions must be analyzed by considering how they impact the essential, necessary, or enhancing aspects of the five human interests. For a technology or therapeutic to be permissible, it must advance the essential aspect of these human interests; otherwise, if it violates "any one of these interests... (it is) classified as unethical and should not be permissible (Islamically)".[50] Somewhat confusingly, however, they note that if a technology presents a conflict between the essential interests where one is advantaged and another is not, the tension should be resolved by recourse to Islamic legal maxims (*qawāʿid*).[51]

In summary, *field-based redefinition* considers the human interests/values of religion (*dīn*), life (*nafs*), progeny (*naṣl*), wealth (*māl*), and intellect (*ʿaql*) in light of biomedicine. As a framework for medical ethics deliberation, the essential *maqāṣid* are envisaged as hierarchical principles. Accordingly, moral obligations and ethical practices are determined by evaluating how the proposed course of action advantages or disadvantages each human interest *qua* principle. According to some theorists, none of the essential interests can be violated for an action to be judged permitted and ethical; others suggest that the moral agent must justify departures from any of the principles by demonstrating that a higher-order principle is preserved. This practical, albeit elementary, distillation of the *maqāṣid* theory into a medical ethics framework is taught widely in the Muslim world.[52]

Approach 2: Conceptual Extension

These approaches involve a greater degree of departure from al-Shāṭibī's theory.[53] In contrast to field-based redefinition, where the human interests are redefined, conceptual extension involves revising other concepts within al-Shāṭibī's theory, incorporating new *maqāṣid,* and utilizing a different rubric for ethical deliberation. Theorists adopting this approach certainly reformulate al-Shāṭibī's essential *maqāṣid* but do much more than that in order to incorporate contemporary science into their theoretical models and practical frameworks. Professors Gamal

Eldin Attia, Tariq Ramadan, Jasser Auda, and Shaykh Yusuf al-Qaradawi belong to this camp.[54] Herein I will describe Gamal Eldin Attia's and Tariq Ramadan's approaches, as both directly apply their frameworks to medical ethics.

Gamal Eldin Attia is an Islamic legal theorist who *conceptually extends* al-Shāṭibi's theory to better incorporate the human, social and physical sciences and a community/societal focus. He does so by (i) amending the concepts of *ḍarurī, ḥajī,* and *taḥsīnī,* and (ii) identifying new *maqāṣid* and reorganizing them within different domains. Recall that al-Shāṭibi considered there to be essential, necessary, and enhancing objectives to Islamic law. Attia extends this notion to assert that there are essential, necessary, and enhancing means (*wasā'il*) by which a particular objective is attained. Consequently, essential means represent those actions and policies required to minimally achieve the *maqṣid* in question. For example, he considers the provision of food to be core to the higher objective of preserving life. When one obtains just enough food to stay alive, the essential threshold of what is demanded by the preservation of life is met. The provision of a balanced and appetizing diet represents the necessary benchmark. It removes hardship and facilitates life, while elegant food presentation and refined table etiquette fall under the category of enhancements as they beautify and perfect the means (e.g., food provision) by which the preservation of life takes place.[55]

As part of this revision, Attia advocates using scientific data to determine the means for achieving the *maqāṣid.* When a particular means brings about significant benefit or removes great harm that means is classified as an essential one. Minor benefits or removal of minor harms through policy or action place that action or policy into the enhancing category, while the necessary means fall between the essential and the enhancing means.[56] This rubric enables Attia's theory to allow actions and policies to change from one category to another based on context and in light of empirical, social scientific, and other data. Having attached the concepts of essential, necessary, and enhancing to means, he discards the idea that they apply to the *maqāṣid* themselves.

Attia then sets about identifying new *maqāṣid.* He considers the present epoch to be a "legislative vacuum" where rapid developments

in human society, knowledge, and technology necessitate the use of human reason to discern new objectives.[57] When building out ethical frameworks, Attia advocates generating specific field-related *maqāsid* and determining the best means to achieve them based on an understanding of the "divine laws of creation" and "definitive facts which have been identified by science" so that the ethical theory is "inclusive of all normative and objective elements" pertinent to the field.[58] Recall that al-Shāṭibī argued that secondary objectives of Islamic law could be discerned by recourse to ratiocination and science; Attia extends this idea by arguing that the primary, i.e., essential, objectives can be identified in the same way.

Hence Attia *conceptually extends* his *maqāsid* model by laying out 24 essential objectives across four domains: (i) the individual, (ii) the family, (iii) the Muslim community, and (iv) the level of general humanity. Detailing all of Attia's *maqāṣid* is beyond the scope of this paper, yet describing those at the individual level, however, will facilitate our forthcoming discussion of medical ethics. Consequently, at the level of the individual, there are five essential *maqāṣid*: the preservation of human life, consideration for the mind, the preservation of personal piety, the preservation of honor, and the preservation of material wealth. While these *maqāṣid* resemble al-Shāṭibī's, in contrast to field-based redefinition, the essential interests are not only redefined; they are reformulated by extending the human interest to include other ideas.

Accordingly, contemporary views about "what is referred to in the law as the right to life...[and] the sanctity of the body" is added to the objective of preserving human life.[59] He further details that the essential means for preserving human life involve (i) protecting the body, (ii) maintaining life, and (iii) protecting against mortal harms. Consideration of the mind expands beyond the traditional view of preserving human intellect to require developing intellectual capacities and utilizing the mind in "intellectual acts of worship."[60] Developing the mind also requires delivering scientific education, building academies, and otherwise nourishing and equipping the rational faculties of individuals. Attia refashions the preservation of religion into the preservation of personal piety, with its essential means including strengthening religious

doctrines, performing the obligatory acts of worship, and focusing on moral formation. The preservation of honor refers to "anything related to human dignity," one's reputation, and the "sanctity of one's private life."[61] The necessary means to secure this interest include preventing people from committing slander and making false accusations through penal injunctions. The preservation of material wealth is accomplished through financial laws and penalties for theft. Additionally, Attia reformulates the preservation of progeny (*naṣl*) into the preservation of the human species along with other family-level objectives.

Attia also revises al-Shāṭibi's hierarchy by suggesting that the preservation of material wealth should be given the lowest priority with the preservation of "family lineage [or progeny], honor, and human reason" occupying a space above material wealth but below the preservation of human life.[62] He also appears to disagree with ranking the preservation of religion above the preservation of human life, because religious life is contingent upon being alive.

Commenting on how his model applies to healthcare, Attia argues that seeking and providing certain types of healthcare are moral duties. These ethical obligations emerge from the *maqṣid* of preserving life. Hence treating infectious diseases and radiation exposure is obligatory because they are "mortal dangers" that can eliminate human life universally.[63] Similarly, physical integrity is central to the preservation of life, and there is an ethical obligation to build trauma systems and hospitals. With respect to reproductive health, Attia considers abortion and hysterectomy to be prohibited because they contravene the *maqṣid* of preserving the human species.

Following this pattern, Tariq Ramadan, a leading Islamic ethicist, also *conceptually extends* al-Shāṭibī's model. His revision also involves redefining and identifying new, human interests and specifying different levels at which they operate. Like Attia, he finds al-Shāṭibī's *maqāṣid* focused on individuals and lacks attention to natural and social scientific data. He argues that an understanding of human interests, e.g., religion, life, etc., "should be developed not only in the light of scriptural sources but also of contemporary knowledge and related ethical requirements."[64] Ramadan builds a theoretical model that integrates scriptural knowledge

with the human sciences, yielding a "theoretical and practical outline of an applied contemporary [Islamic] ethics."[65] Therefore his extension involves identifying new higher objectives "on the basis of the two Books [revelation and nature]" and by "taking into account the evolution of our knowledge in the two fields of study (text sciences and the sciences of the universe)."[66]

Ramadan's framework operates at three levels: the inner being, the individual and small groups, and society. In this way, his and Attia's models are alike. However, Ramadan innovates by placing a few governing *maqāṣid* upstream to these levels noting that they operate "even before getting down to the specification of human action."[67] In his view, there are two overarching objectives from which all Islamic laws, policies, and ethics issue forth are (i) "the protection of *dīn*" by which he means "a conception of life and death" according to Islamic theology, and the protection of "*al-maṣlaḥa*" which he defines as "the common good and interest of humankind and the universe." Underneath these are three core ethical values "respecting and protecting life (*hayāh*), nature (*khalq*), and peace (*salām*)."[68] These three objectives are the "pillars" and "*a priori* goals" for Islamic moral frameworks. He next enumerates a final superstratum of values that reside below these three objectives but precede *maqāṣid* at the individual, group, and societal levels. These are "promoting and protecting dignity (of humankind, living species and nature), welfare knowledge, creativity, autonomy, development, equality, freedom, justice, fraternity, love, solidarity, and diversity."[69] Detailing Ramadan's conceptions of each of these values is challenging, for he admits that scholars of Islam and of the natural and social sciences are needed to elaborate on these concepts and to integrate the religious and secular sciences in doing so. Both camps of experts must also determine how the *maqāṣid* can be achieved and when they are at risk.[70] Nonetheless, he utilizes his work-in-progress model to generate medical ethics rulings.

In his view, preserving the highest-order objectives of "the Islamic conception of life and death [which is his revised formulation of the preservation of religion *dīn*] and of people's common good and interest (*al-maṣlahāh*)" are the overarching ethical mandates of an Islamic

bioethical framework.[71] These objectives are transformed into the primary end-goals of healthcare from which second-order ethical duties emerge. The second-order *maqāṣid* are the preservation of life, of personal integrity, and of human dignity. He holds that these *maqāṣid* must be understood through an integrative reading of scripture and the health sciences. As an illustration, he addresses the ethics of end-of-life healthcare. With respect to whether it is ethical for a physician to assist a patient in ending their life, he judges it forbidden because assisted suicide contradicts the highest-order objective: an Islamic understanding of life and death; and it also contravenes the objective of preserving life. According to him, an Islamic understanding of life and death entails accepting that God decrees an individual's moment of death, and one should not take action to hasten it. This understanding also requires patients and physicians recognize that illness may serve a spiritually purifying function. At the same time, he holds that physicians are morally obligated to provide palliative care because it coheres with the *maqṣid* of preserving human dignity. He also states that the preservation of dignity demands that patients and their families are free to choose "being kept alive mechanically," "to use all curative means available," or to "accept the decree of fate" when near the end of life.[72] This example illustrates how moral duties in healthcare emerge from trying to achieve and not contravene the objectives.

In summary, the *conceptual extension* approach redefines the human interests contained within al-Shaṭībī's essential *maqāṣid* by drawing on contemporary social and scientific understandings. Also, it incorporates new *maqāṣid* that align with scriptural sources as well as social and natural scientific data. The medical ethics framework that emerges from this approach is quasi-deontological, as moral obligations are derived by setting the *maqāṣid* as end-goals for healthcare delivery which must be maximized.

Approach 3: Text-Based Postulation

The *text-based postulation* method for further developing al-Shāṭibī's theory involves explicating the visions of human and societal flourishing

embedded within al-Shāṭibī essential *maqāṣid.* This vision of life represents the base conditions demanded by Islamic morality. Means (policies and actions) to achieve this vision are identified by drawing upon natural and social scientific data. Building upon these basic thresholds for human existence, secondary *maqāṣid* are determined via inductive readings of scripture or by recourse to human reasoning about reality. Accordingly, the necessary and enhancing objectives add additional ethical obligations propelling human life from an essentialist (minimal) level to a flourishing one. Notably, the text in text-based postulation refers to al-Shāṭibī's model as the basis upon which one asserts a moral vision for society.[73]

This approach differs from field-based redefinition and conceptual extension in that the human interests identified by al-Shāṭibi are left as he defined them (based on an inductive reading of scripture), and it differs from conceptual extension in that new *maqāṣid* that become part of the framework are subordinate to the essential ones identified by al-Shāṭibi. In terms of prioritization of interests, al-Shāṭibī's hierarchy is maintained. At the same time, the approach allows for knowledge from the human, social, and natural sciences to specify how the *maqāṣid* are accomplished. The ethical frameworks that emerge remain almost entirely consistent with al-Shāṭibi's theory. Glimpses of this approach are seen within the writings of several scholars, but a complete exposition remains to be undertaken.[74]

The *text-based postulation* strategy provides insight into what should be the ends of healthcare and sets up ethical assessments based on these postulated end goals. For example, let us examine moral duties that emerge from the higher objective of preserving life. Al-Shāṭibī sets out several ways to actualize *ḥifẓ an-nafs.* First, procreation, which is the means by which life is produced, requires legitimation; procreation cannot be universally outlawed. Second, preserving life equates to maintaining life, and providing food and drink and educating oneself and their progeny about lethal foodstuffs become part of the *maqṣid.* The third ethical obligation is to provide clothing and shelter, ensuring human survival from natural threats.[75] Finally, the preservation of life entails criminalizing the taking of life.[76] Should these essential/minimal/base aspects of human health be protected, the corresponding state of living

would result in the individual being minimally nourished and clothed, having their procreative capacity intact, and residing in a dwelling that offers protection from inclement weather. With this vision as an end goal, healthcare stakeholders would be morally obligated to furnish this base level of "comfort" to humanity.[77] Current social and empirical knowledge will determine the actions and policies that bring about this minimalistic level of human living. Similarly, in the realm of healthcare, it would appear that reproductive health is central to al-Shāṭibī's theory, for if humankind lost the capacity to procreate, then life in a universal sense would be at risk. Thus healthcare systems, and by extension physicians, are ethically responsible for assisting patients in maintaining their reproductive capacities.

Testing the Utility of *Maqāṣid al-sharīʿah*-based Islamic Medical Ethics

In order to critically examine the merits and shortcomings of the three models mentioned above for medical ethics deliberation, I will use the case of a pregnant woman declared "brain dead" at 19 weeks gestation. Our two ethical questions are as follows: (i) what are the overall goals of care for such a patient, and relatedly (ii) what are the ethical duties of surrogate decision-makers, specifically the attending physician and the husband, towards her healthcare. Before proceeding further, a few medical and religious understandings need to be stated. First, brain death is a misnomer and a highly controversial clinical state from the perspective of Islamic law. Islamic jurists generally hold differing views as to what the state represents; some consider the state of being sufficient for declaring legal death in Islam, others believe it is a state of dying or unstable life, and a third group considers a brain dead individual to be accorded the same status as a living person.[78] However, it is beyond dispute that a brain-dead patient can gestate an embryo and undergo labor when provided with appropriate medical care.[79] Furthermore, the limits of fetal viability vary between 22 and 26 weeks of gestation. In other words, different hospital systems and states set the minimum age of fetal viability differently based on their capacities for neonatal intensive

care. Data suggests a rule of thumb that approximately 25% of births at 23 weeks, 50% at 24 weeks, and 75% at 25 weeks of gestation will survive to hospital discharge in modern hospital systems.[80] From a religious standpoint, 19 weeks gestation is beyond the posited timing of the ensoulment of the fetus, which occurs at 120 days or 40 days of fetal age based on the prevailing views.[81] Hence, the fetus is not yet clinically viable but has a quasi-independent moral status as a human being within the tradition.

Field-based redefinition models result in a principle-based approach to medical ethics deliberation, where moral goals related to preserving religion, life, progeny, wealth, and intellect, are all redefined with respect to healthcare understandings of these terms. Taking Kasule's exposition as an exemplar, these interests are transformed into worship, life, procreative capacity, societal wealth, and mental health. A principle-based approach would require determining which of these objectives are furthered by a specific act and, if some goals are furthered and others violated, assessing whether higher-order goals are preserved. A lawful act would preserve all, or at a minimum, the higher-order interests. Working through the case, the highest objective of preserving capacity for worship is not possible for the mother, given that a brain death diagnosis represents the inability to restore an individual to a conscious state using available medical therapies. Thus, the necessary cognitive status to pray and perform meritorious works is unattainable. With respect to the preservation of life, the analysis hinges on whether the state of brain death is analogized to a dead, dying, or living state. If the state is not considered to be a legally, metaphysically, nor physiologically dead state, then the preservation of life would be attained by keeping the patient on life-sustaining technology.[82] With respect to the objective of maintaining procreative ability, should the patient be kept on life support and eventually deliver a live child, then this goal is furthered. The preservation of mental health is not relevant in our case because the patient will not regain a conscious state. Finally, concerning preserving societal wealth, the costs of intensive care for such a patient are incredibly high, e.g., thousands of dollars a day, and maintaining life support would drain the financial resources of both the family and other responsible parties. Thus, for the mother, the preservation of life

and procreative capacity is furthered by maintaining life support, while the preservation of societal wealth is disadvantaged. Given that the preservation of life and procreative capacity have higher priority than the preservation of societal wealth, the framework would suggest that the end goal of medical treatment should be to maintain the patient on life support as long as possible and until fetal viability at a minimum. If the mother were considered a dead person, the analysis would be similar, because the preservation of procreative capacity would be furthered by maintaining her on life support until the fetus is delivered. Additional support for such courses of action is found by analyzing the scenario from the fetus' standpoint. Indeed, the preservation of life becomes possible by maintaining life support on the pregnant mother until the fetus is viable to deliver. The fetus' future capacity for worship, procreation, and intellection are all similarly advantaged, given that life is instrumental to these interests. Again, societal wealth would be threatened, but given its lower priority, the ethical end goal would be to maintain life support until fetal viability.

With respect to the ethical duties of the treating physician and the husband who serves as the surrogate decision-maker, they must work towards meeting the goals of care outlined above. The physician (and his/her team) are morally responsible for maintaining life support technologies as well as medical treatments that can sustain the mother's physiological functions of life and gestational functions. Additionally, they must apply therapies that will assist the fetal organs in maturing such that it is viable for delivery. Once the fetus is delivered at the appropriate gestational age, the duty to care for the mother may or may not continue depending on whether she is considered a living or dead person. The husband is similarly charged, as his ethical duty to both his wife and potential child is to protect their lives as far as possible.

The *conceptual extension* models lead to medical ethics deliberation that involves setting the new *maqāṣid* as end-goals for healthcare. Recall that both Attia and Ramadan desire social and natural scientific knowledge to be integrated into the conceptualizations of human interests and how they are preserved. As such, biomedical knowledge should, theoretically, inform the ethical objectives proceeding from the human

interests and how they can be best accomplished. Attia considers the preservation of human life to be the most important ethical imperative and designates it to include a right to life and preserving bodily sanctity. In our scenario, setting this as the end goal of healthcare would suggest that the mother's life and the sanctity of her body should be maintained as far as possible.[83] Among the other essential human interests and accompanying objectives, namely consideration of the mind, personal piety, honor, and material wealth, the only one that applies in our scenario is material wealth. Preserving human life in our scenario would entail sacrificing material wealth; however, given that human life is more important than wealth, preservation of life would be maximized. However, the challenge is that components within the objective of preserving life are at odds. If one believes that the brain dead patient is alive, then maximizing her right to life requires violating her bodily sanctity by supporting her breathing via invasive mechanical ventilation, disrupting the integrity of the body with catheters that collect urine, tubes that provide nourishment through the alimentary canal, and intravenous tubing that provides medications and fluids as needed. Clinical science and biomedical research would support these medical interventions as necessary to maintain bodily functions in a brain-dead state. Thus, Attia's model would declare these to be necessary means backed by scientific data. Considering the perspective of the fetus, a similar conflict arises. As an ensouled being, the fetus also has a right to life, and its life should be preserved. However, to preserve its life, the bodily sanctity of the mother must be violated, for she would need to be maintained on maximal life support and be given medications for the fetus to be successfully gestated and delivered. Overall, given that one aspect of the end goal conflicts with another, setting the preservation of human life and its components of a right to life and bodily sanctity as the overarching end goal for healthcare does not provide clear insight into the ethical course of action in this scenario. One possible solution would be to declare the mother dead and accept the violation of the sanctity of a dead body to maximize the fetus's right to life. Alternatively, one could consider the physiological functions of a brain-dead patient to be sufficient markers of human life and preserve her life at the cost of her

bodily sanctity. The most prudent course of action may be to maintain the pregnant woman's life and accept the many clinical interventions and accompanying costs required to do so. In this way, part of the objective is met, and both she and the fetus's life is protected. At the same time, ethical deliberation over the meaning of brain death appears necessary, and Attia's theory would defer to social and natural science in this realm. Unfortunately, controversies abound since death is a social construct that brings together purposes, criteria, and behaviors, and the ontological reality of death cannot be resolved from social and natural scientific data.[84] It follows from the preceding analysis that the ethical duties of the treating physician and the husband would be to maintain life support.

Prof. Ramadan reconceptualizes the objective of preserving religion (*dīn*) into preserving an Islamic conception of life and death. Alongside this objective is seeking the common good and interests of humankind which he links to the Islamic legal construct of *maṣlaḥa*. These overarching *maqāṣid* are supported by numerous ethical duties related to promoting life, nature, and peace. Taking this framework as a starting point for analysis, we run into similar troubles in setting the end goals for healthcare in our hypothetical case. What is an "Islamic" conception of life and death? And how is it to be maximized? Ramadan would seek answers from scripture and science here, but both domains of knowledge lead to ambiguous answers. From a scriptural perspective, while a metaphysical definition of death as the departure of the human soul from the body can be gleaned, the physical markers of such are not definitive. Both classical and contemporary Islamic theologians debate the reality of the soul and how its functions are manifested bodily.[85] They also debate when ensoulment of the human body occurs based on different readings of the scriptural sources.[86] And with respect to the signs of death in the body, scholars assert that the signs noted in legal manuals are either based on custom or based on the testimony of experts; in other words, they are not scripturally grounded. Indeed, this view allowed for accepting neurological criteria for death as sufficient markers for legal death in Islam.[87] Hence concerning a scripturally-grounded conception of life and death as it relates to ensoulment and bodily manifestations, one cannot claim there to be uniformity or a singular view. Ramadan

may seek answers from natural theology and biomedical science, but these cannot offer much insight into our scenario. Again the brain-dead patient is "betwixt and between" traditional notions of life and death and challenges religious and biomedical constructs on both ends.[88] A clear end goal for healthcare that protects Islamic conceptions of life and death is out of reach.

Looking to the other overarching objective of promoting humankind's common good and interest does not suggest a clear end goal either. Does society benefit from, or is it harmed by, maintaining a pregnant brain dead woman on life support? Arguments could be made either way, as there is undoubtedly a fiscal cost to bear for such maintenance, yet the addition of a citizen to society can yield fiscal benefit. Economic analysis may suggest maintaining the patient until fetal viability and then withdrawing life support. But there are social costs of doing so; how would families feel when their loved one's life is reduced to that of an incubator? How would clinicians and nurses feel when asked to apply maximal life support to what the law would suggest is a corpse? Hence, this other overarching objective does not provide a clear answer either. Accordingly, the physician and husband's ethical duties remain unclear.

Moving to *text-based postulation,* medical ethics deliberation here would require explication of a moral vision for healthcare based on al-Shāṭibī's essential *maqāṣid.* This vision would be supported by secondary objectives and means identified by science. As detailed above, al-Shāṭibī's *ḥifẓ an-nafs* sets up a vision of health that is minimalistic. The base level of human health it sets as an ethical requirement is one where an individual is minimally-nourished and clothed, has his/her procreative capacity intact, and resides in a dwelling that offers protection from inclement weather. With this vision as an end goal, Islamic medical ethics stakeholders would be morally obligated to develop healthcare systems that address these social and physical determinants of health.[89] In our case scenario, this base level of living can be attained for the mother in the hospital, provided we consider her to be alive. Intravenous and/or alimentary nutrition can be provided, the patient can be clothed, and hospitals are structurally intact enough to protect her from inclement weather. Beyond this, based on biomedical knowledge, other moral

duties that help preserve her life may be added. For example, providing supportive care to maintain the patient free of infections, grooming, and other measures would be considered secondary moral duties that complement and support life preservation. If she were judged to be a dead person, the fetus's perspective may be considered. Preservation of its life demands a similar state of living as the mother, and it can only be achieved by maintaining the mother on maximal life support. Accordingly, the physician and husband's ethical duties are to maintain life support and ancillary treatments for the mother (and thereby fetus).

Shortcomings of the *Maqāṣid*-based Medical Ethics Frameworks

While all three frameworks provide solutions, they also contain theoretical and practical ethics gaps. In terms of answers, similar ethical answers can be gleaned. Each method of medical ethics reasoning suggests that the mother should be kept on maximal life support, and this action would be entailed by the various configurations of the *maqṣid* of preserving life. At the same time, this action would assist in the preservation of the fetus's life, whose right to life is also covered by the same objective. The field-based redefinition models suggest that the costs associated with this course of action disadvantage the lower priority objective of preserving societal wealth yet further the preservation of the procreative capacity of the mother. Overall, the action is justified and morally obliged.

Attia's conceptual extension model combines moral duties to preserve bodily sanctity with the preservation of life, and the suggested course of action creates opposing tugs within this singular end-goal for healthcare. Yet the course of action appears to be justified. On the other hand, Ramadan's model is ambiguous about the end goals. The text-based postulation model also sanctions the proposed course of action as it fulfills the minimal vision of health obligated by the *maqsid*. The preservation of progeny is also advantaged. In short, these *maqāṣid*-based versions for medical ethics deliberation would require healthcare stakeholders to do all they can to maintain the mother's life.

From a practical standpoint, none of the proposed frameworks, nor their undergirding theories, provide insight into the limits of this

obligation. While al-Shatibi's theory considers the preservation of religion to be of higher priority than the preservation of life, that notion provides no practical guidance to the text-based postulation model employed to address the case scenario. Illustratively, should the mother's life be considered of lesser value than others because she cannot perform acts of salvific nature given no capacity for consciousness and volition? Is the potential life of the fetus prioritized over the pregnant mother because it holds the potential for future religious practice while the mother does not? Ramadan refashions the preservation of religion into duties to preserve Islamic conceptions of life and death, but as mentioned above, there is little conceptual clarity about what this entails. The other models obligate the preservation of life seemingly at all costs. Real-world application would introduce many different constraints to such a moral obligation. In addition to fiscal constraints, many localities, including Muslim jurisdictions, consider brain death to be a legally dead state despite the many clinical and ethical controversies it entails.[90] Muslims trying to live out an Islamic ethical vision based on these *maqāṣid* would have to either find legal recourses to maintain the patient on life support or accept their inability to live out Islamic ideals due to political constraints. Additionally, the human costs of such maintenance are not accounted for. Social scientific research finds that individuals suffer considerable emotional stress when loved ones are in the intensive care unit and that long-term support of individuals without hope for meaningful recovery can lead to familial discord and disruption of caregiver's life plans.[91] My point here is not that withdrawal of life support is the most ethical course of action, just that medical ethics deliberation based on the *maqāṣid* is posited to better account for empirical and social scientific data. In our scenario, it is not clear how these data are to be incorporated. From a practical standpoint, the *maqāṣid*-based medical ethics frameworks appear to have real shortcomings.

When compared to extant *fiqhī* rulings, other gaps appear. None of the frameworks address the thorny issue of brain death by detailing a conception of human life or describing a human life that is worth living. Islamic jurists have debated the acceptability of neurological criteria for death declaration in Islam for decades.[92] While proponents and

detractors exist, there is a zone of near consensus and an operative plurality on the issue. Several international Islamic juridical councils have judged it legally permissible to withdraw life support when brain death is declared, basing their views on deference to medical authorities, on legitimating the scientific rationale for death declaration, or on classical rulings that consider medical care to be non-obligatory.[93] Even scholars that do not hold brain death to meet the legal standards of death in Islam permit condone withdrawing life support when such a state is reached, though they suggest that death should be declared when the heart stops irreversibly.[94] Hence the near-consensus view is that life support can be withdrawn. However, scholars may differ on what the underlying Islamic grounds for such action are and whether death can be declared based on neurological criteria. The *maqāṣid*-based medical ethics models would contradict these *fiqh*-based rulings.[95] Or, at a minimum, the *maqāṣid*-based analyses suggest that the general ruling is not applicable, given the added dimension of pregnancy. Similarly, *maqāṣid*-derived notions of preserving life at all costs seem to counter the ethical notions embedded within the four Sunni schools of the non-obligatory nature of medical treatment except for when the treatment is assuredly life-saving for the patient.[96]

Limits on medical treatment are also introduced, based on scriptural notions of human dignity. Every clinical therapy disturbs the *ḥurma* (inviolability) and *karāma* (sanctity) of the human body. Hence jurists argue that these violations are only to be accepted when treatment efficacy is high, e.g., surgery for appendicitis, and when a positive outcome is expected. However, when there are no viable "good" outcomes, these violations should constrain clinical interventions. Given the interminable march of a patient diagnosed as brain dead towards cardiopulmonary collapse and there being no possibility for recovery to a consciousness state, one may argue that the disruption of *ḥurma* and *karāma* tilt the equation towards the withdrawal of life support.[97] The *maqāṣid* models appear not to account for such concerns. Even when notions of bodily sanctity and human dignity are incorporated within frameworks, these human interests are subordinated.[98] Even if the patient is judged to be a dead human, the preservation of progeny supports maintaining life

support despite threats to human sanctity and inviolability. This idea of instrumentalizing the mother's life to facilitate the fetus's has no legal precedent. Indeed, the dead body can be violated to achieve justice by retrieving lost property, for example, and a nearly dead pregnant woman can be dissected to save the fetus.[99] However, our case involves using the mother's body as an incubator for several weeks, thus tolerating the violation of bodily sanctity of a dead or nearly dead woman. Although proponents argue that *maqāṣid*-based models for ethico-legal deliberation reflect the spirit of the law, the ways in which the aforementioned medical ethics models are seemingly misaligned with extant rulings call for caution. Opting for *maqāṣid*-based reasoning to the exclusion of *fiqh* methods in Islamic medical ethics deliberation may be ill-advised.

Proceeding upward from practical ethics concerns, methodological issues also generate problems. A field-based redefinition approach transforms health into the ultimate human interest and refashions *maqāṣid* into hierarchical ethical principles servicing health. This approach can fall prey to relativism. Since the interests—religion (*dīn*), life (*nafs*), progeny (*naṣl*), wealth (*māl*), and intellect (*ʿaql*)—are defined according to common understandings, these interests can be defined variably by different cultures, have multiple different configurations within and across societies, and may change from epoch to epoch. This sort of relativism undermines the argument that the *maqāṣid* frameworks speak to universal moral norms. Indeed, Beauchamp and Childress's widely-utilized four-principle medical ethics model is critiqued for much the same reason.[100] Assuredly human interpretation of principles introduces plasticity that can help the framework adapt to different times and contexts. Yet, by removing the scriptural anchor that bounded the definitions of religion, life, progeny, wealth, and intellect, the concepts become susceptible to widespread variability and may be redefined almost at a whim. Illustratively, traditional views conceive of the human interest of *māl* as personal physical property. However, Kasule redefines the essential interest of *māl* as societal wealth, and Saifuddeen includes intellectual property in his vision for this human interest. With scholars and practitioners defining the interest differently based on field-specific understandings, a cohesive and uniform Islamic moral vision for society

seems impossible. Moreover, the posited "Islamic" nature of the bioethical theory becomes somewhat suspect when the human interests and the ethical duties that surround them are no longer rooted in revelation.

Additionally, although the proposed hierarchy is supposed to address conflicts between principles, the hypothetical case brings up an issue endemic to al-Shāṭībī's theory. In his view, the interest of religion ranks above life, and therefore moral duties to preserve religion supersede obligations related to preserving life. The posited field-specific redefinition frameworks revise this hierarchy while introducing ethical conflict. For example, in our case, the physician's moral obligation is to continue to apply advanced technology to maintain the patient's life, even in a severely compromised neurological state where worship is not possible and financial costs are high. In this scenario, preserving religion is not possible while preservation of societal wealth is threatened, yet it appears the moral duty to preserve life supersedes all other concerns. Even if the patient is judged to be dead, preserving the procreative capacity of the mother and/or the preservation of the fetus's life may demand maintaining life support. The theorists elaborate no limits. A framework without constraints on maximizing principles is not only impractical, but it also misses acknowledging the actual limitations on human actions.

Finally, there are some unresolved issues pertaining to the *maqāṣid* model itself. The theorists do not appear to consider necessary and enhancing objectives of Islamic law. They neither enumerate them nor identify a role for such secondary objectives within their version of Islamic medical ethics. In al-Shātibī's theory, these secondary objectives support the essential objectives and allow the framework to evolve based on knowledge from contemporary natural and social sciences. Given the conspicuous absence of these subsidiary objectives, one wonders how such medical ethics frameworks would stand the test of time to adjudicate matters that lie outside of the five essential *maqāṣid*. Moreover, it is unclear how the model would advance the social and political conditions to support meeting the essential objectives.

The *conceptual extension* approach identifies new means to achieve the classical essential *maqāṣid* by drawing upon contemporary knowledge and identifies new *maqāṣid* based on scripture and science. This

version of a medical ethics framework sets moral duties cohering with these *maqāṣid*. The principal challenge for such a framework is understanding the Lawgiver's intent, and thereby ascertaining the normative order of things. Ramadan ascribes normative value to nature such that it stands alongside scripture as the foundation for objectives and, thereby, moral duties. Attia values natural and social scientific understandings. For medical ethics deliberation, the challenge is harmonizing these multiple understandings to define the normative body and its natural telos. For example, if one were to look to nature to understand the value of reproductive organs, one may suggest that they are present for procreative purposes. At the same time, the Qur'an relates that God makes some individuals infertile. How would one determine an Islamic bioethical perspective on fertility treatment by simply looking at these sources for moral guidance? Some may term infertility a disease that obligates remedy, while others may consider the lack of offspring to require acceptance of divine decree. Would an Islamic healthcare system be obligated to research and fund therapies that restore function to a patient's reproductive organs? Similarly, the issue of brain death exemplifies biomedical understandings and data may not yield the desired result. Instead, a normative fallacy appears: biology and science may describe reality and generate facts but the values ascribed to these must come from elsewhere. Previously scriptural hermeneutics would be utilized to discern values. However, the conceptual extension approaches do not detail how to do so. These theories do not describe the parameters under which scientific facts inform the conceptualization of human interests. In other words, since reality and scripture both inform our understanding of the human interests to be preserved and the means to achieve such preservation, is there a privileging of one over the other?

A medical ethics schema based on text-based postulation is also not without problems. The strength of the model is also its weakness. The schema remains wedded to al-Shāṭibi's conceptual definitions of the essential human interests, which are based on his inductive reading of scripture. This fixation is particularly problematic when considering the evolution of human knowledge and societies since the 14th century, when al-Shaṭibī was designing his *maqāṣid* theory. In this way, a redefinition of

the essential *maqāṣid* is precluded, and the theory is not easily adapted to advancements in human knowledge and capacities. In a related fashion, the approach precludes a reordering of *maqāṣid,* as there appears to be no route by which a rationally advanced necessary *maqṣid* can transform into an essential one based on context. To illustrate this challenge, consider medicine's ability to intervene in disease. Today, such technical capabilities are vastly greater than in the 14th century, when al-Shaṭibī determined the moral duties surrounding the preservation of life. How would one update the model to reflect this? Contemporary scholars may suggest that the provision of healthcare, *a la* Attia, is part and parcel of the essential *maqāṣid* of preserving life because human existence depends on being free of fatal diseases. While text-based postulation might consider such provision to be a necessary means of preserving life, it will not be judged to be an essential one, and therefore it is not morally obligated unless there is a clear indication that the life, universally, is threatened if such an action is not taken. Hence this medical ethics framework does not easily allow for broadening the essential *maqāṣid* and thus limits its flexibility across time and space.

The practical ethics challenges, conceptual ambiguities, and other shortcomings of the *maqāṣid*-based medical ethics frameworks may be explained by their works-in-progress nature. Muslim thinkers concede that their *maqaṣīd* theories and ethical frameworks will require further development as they come to be applied in various disciplines and fields. Nonetheless, it is vital to highlight the challenges these attempts face to spur future clarifications and revisions.

Future Directions: The Intersection of *Maqāṣid*, Medical Ethics, and Biomedicine

Maqāṣid-based medical ethics models are increasingly introduced into Islamic bioethical discourses, mainly for reasons of pragmatism and posited utility. Advocates champion these tools as delivering the spirit of Islamic morality without the burden of requiring specialist knowledge of *fiqh* and scriptural hermeneutics to make moral judgments. The tools are also advocated as being weighed down by historical social constructs.

Consequently, *maqāṣid* models are set as instruments for rebalancing Islamic bioethical discourses by centering them around healthcare practitioners instead of jurists and by rooting them in the reasoning exercises of healthcare stakeholders in the contemporary era rather than being anchored to *fatāwā* and outdated societal configurations. While the models may furnish ethical concepts rooted in the Islamic moral tradition, the frameworks appear replete with conceptual, methodological, and practical shortcomings.

Beyond this, using *maqāṣid al-sharīʿah* theories and frameworks to adjudicate ethical duties and propose treatment plans at the bedside may be inappropriate because of what they represent. The *maqāṣid* are human interests that the Lawgiver legislates on the basis of, and as such they aid legists in discerning *fiqh*. Classical theorists sought to complement *fiqhī* methods and reorient rulings developed by expert legists by introducing the theories of *maqāṣid al-sharīʿah*. By supplanting *fiqh* and scholars of *fiqh*, contemporary thinkers have replaced the time-tested reasoning exercises and sophisticated ethico-legal concepts of *fiqh* with ones that are much less honed and cogent.

Instead, more appropriate usage of the *maqāṣid* would be to treat them as ethical end-goals that should be maximized by social systems, including legal ones. Both classical theorists and contemporary thinkers agree that *fiqh* exercises have become too focused on the permissibility of singular acts and that legists sometimes use strained logic to resolve the concerns of individual Muslims. Both groups argue that a broader vision of the Lawgiver's interest in legislating for the benefit of humankind is needed to refocus the generation of *fiqh* and *fatāwa*. Instead of using the *maqāṣid* for building frameworks for medical ethics deliberation and determining the ethics of an act, they should be utilized as a check to determine which rulings best serve the ethical end-goals of Islam. Said another way, *maqāṣid*-based analyses could provide a quasi-sorting or controlling function by helping decision-makers select the best course of action among the various courses of action deemed to be permissible by *fiqh*.

As an aside, another argument for *maqāṣid*-based medical ethics frameworks is based on the idea that Muslim clinicians need a working

knowledge of Islamic morality to live out Islamic ideals in medical practice; they need to be 'inoculated' against acting according to secular visions of medical ethics. Therefore, *maqāṣid*-based frameworks are better suited for quick uptake and easy understanding. Unfortunately, the lack of constraints and balancing mechanisms within *maqāṣid*-based ethical frameworks, and their conceptual ambiguity, make them poor substitutes for more secular medical ethics systems that draw on robust principle and virtue-based theories. In my view, the Islamic legal tradition already contains a genre of pithy and robust ethical concepts, the *qawāʿid al-fiqhiyya*, that can be quickly understood by non-legal specialists and serve as foundations for ethical thinking. Moreover, this genre also has built-in balancing and constraining tools, *ḍawābit,* which would help prevent clinicians from utilizing the ethico-legal maxims inappropriately. As such, this genre is much more suited for Islamic medical ethics training.

Certainly, *maqaṣīdī* approaches can help tie different strands of Islamic ethical reflection together to furnish a comprehensive and compelling Islamic bioethical theory. While Islamic law focuses on the moral significance of acts, Islamic virtue ethics aims at the moral formation of the agent. I contend that *maqāṣid*-based ethical frameworks delineate end goals and bring holism to the field, when used appropriately. Since the *maqāṣid* reflect the divine intents which involve protecting human interests, *maqāṣidī* bioethical frameworks provide insight into what the Lawgiver intends for humanity to work towards; they can describe a vision of human flourishing that humankind should aim for. Indeed, the three disciplines would cover act-morality, agent-morality, and end-goal morality. Metaphorically, the *maqāṣid* would clarify the destination to be reached, *fiqh* would map out the multiple ways of getting there, and teaching Islamic virtues would assure that one has enough fortitude to undertake the journey. Obviously, for the *maqāṣid* to illuminate the moral goals, they must be unambiguous, robustly conceptualized, and closely connected to scripture.

Finally, Muslim thinkers advocating for *maqāṣidī* thinking in medicine have focused on inserting these frameworks into medical ethics. They hope that by reforming ethical deliberation, modern healthcare

delivery will move closer to being aligned with Islamic morality. Indeed, contemporary healthcare is delivered as part of a cultural system containing ontological, epistemic, ethical, and social frameworks. The idea of gaining a toehold within the ethical realm and then moving outward to systematically reform the healthcare system is laudable. Yet, starting with ethics may be too downstream of a starting point, for the way in which modern medicine is set up within society prefigures certain types of ethical concerns and leads to specific conflicts among its various stakeholders. Injecting Islamic moral values to resolve a conflict at the bedside between two available courses of action does not necessarily open up different courses of action. Said another way, Islamic moral frameworks may help clinicians and patients determine which of the *available* courses of action are more in line with the tradition, but reforming medical ethics deliberation at the bedside may not introduce *new* courses of action nor *change* the available options.

Controversies over brain death exemplify this notion. Because most of society values human consciousness as a marker of personhood, it is largely acceptable to consider the loss of consciousness as the death of an individual. Furthermore, because healthcare payors more highly compensate chronic disease management and high technology solutions than disease prevention modalities, diseases like high blood pressure and diabetes run rampant and lead to kidney failure, which demands solutions such as organ donation and transplant. Consequently, brain death becomes a much more valuable construct because it allows for organ donation and transplantation, which save the lives of individuals stricken with vital organ failure. This social structure leads to questions about the meaning of death, conflicts between families and clinicians over decisional authority to donate organs, and whether religious exemptions or conscience claims can be advanced to consider individuals meeting neurological criteria for death as still alive. Advocating for the sustaining of life support for a patient declared brain dead because that is more aligned with Islamic morality does not appear to be the logical starting point by which to address the cultural, ontological, social, legal, and epistemic frameworks that support the notion that brain death is the death of the human being, nor addresses the larger healthcare purposes,

e.g., organ donation, that the entity is needed to facilitate. A project to "Islamicize" biomedicine, by which I mean aligning biomedicine with the Islamic moral tradition, does not require advancing a "missionary bioethics" based on the *maqāṣid* frameworks.[101] Instead, developing a constructive critique of contemporary healthcare by evaluating whether the ways in which healthcare is instantiated within society serves the human interests legitimated by the *maqāṣid* might be a better starting point for reformation.

Endnotes

1 Pew Research Center, "Mapping the Global Muslim Population," Mapping the Global Muslim Population, October 7, 2009, https://www.pewforum.org/2009/10/07/mapping-the-global-muslim-population/.

2 The term bioethics has many different definitions, but is a broad field of study that encompasses the ethical, social, and legal issues that arise in the life sciences and biomedicine. Bioethics discourses thus occur within many different settings including the hospital, the home, on public media and within legislative bodies. As a field bioethics is expansive and can be considered to contain several subfields including clinical medical ethics (or medical ethics for short) which focuses on issues arising at the level of the patient, family, and doctor during the course of healthcare decision-making. The focus of this paper will be on medical ethics as the realm of application for frameworks based on the higher objectives of Islamic law. See also Yacoub Ahmed, Abdassamad Clarke, and Abdel Aziz, *The Fiqh of Medicine: Responses in Islamic Jurisprudence to Development in Medical Science* (London: Ta-Ha, 2001); Abdulaziz Abdulhussein Sachedina, *Islamic Biomedical Ethics: Principles and Application* (New York: Oxford University Press, 2009); Mohammed Ali Al-Bar and Hassan Chamsi-Pasha, *Contemporary Bioethics* (Cham: Springer International Publishing, 2015); Alireza Bagheri and Khalid Abdulla Al-Ali, *Islamic Bioethics: Current Issues and Challenges* (London: World Scientific Publishing Europe Ltd., 2018); Aasim I. Padela, and Ebrahim Moosa, *Medicine and Shariah: A Dialogue in Islamic Bioethics* (Notre Dame: University of Notre Dame Press, 2020).

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5 Omar Hasan Kasule, "Biomedical Ethics: An Islamic Formulation," *Journal of the Islamic Medical Association of North America* 42, no. 1 (April 2010).

6 Gamal Eldin Attia, *Towards Realization of the Higher Intents of Islamic Law: Maqasid al-Shari`ah: A Functional Approach* (Herndon, VA: International Institute of Islamic Thought, 2007); Jasser Auda, *Maqasid al-Shari`ah: A Beginner's Guide* (London: International Institute of Islamic Thought, 2008).

7 Mohammad Hashim Kamali, *Maqasid al-Shariah, Ijtihad and Civilisational Renewal,* Occasional Papers 20 (London: International Institute of Islamic Thought, 2012); Jasser Auda, *Maqasid al-Shariah as Philosophy of Islamic Law: A Systems Approach* (Washington D.C.: International Institute of Islamic Thought, 2008).

8 This paper focuses on the intersection of *maqāṣid* with medical or clinical ethics decisions, rather than the larger field of bioethics.

9 Brain death is a misnomer and highly confusing entity. It is not total brain failure from a physiological sense, nor do criteria for assessing brain death require testing all parts of the brain. It is more appropriately thought of a prognostic entity than a diagnostic one. For the purposes of this paper I use the term to represent the clinical state of a human being that corresponds to meeting the neurological criteria for death in a legal jurisdiction. It is important to recognize these criteria may vary from country to country.

10 Imran Ahsan Khan Nyazee, *Theories of Islamic Law* (Islamabad: Islamic Research Institute, 2005); Ibrahim ibn Musa al-Shatibi, *The Reconciliation of the Fundamentals of Islamic Law,* translated by Imran Ahsan Khan Nyazee (Reading, UK: Garnet Publications, 2011).

11 Imran Ahsan Khan Nyazee, *Islamic Jurisprudence: Usul al-Fiqh* (Islamabad: Islamic Research Institute, 2000); Subhi Ragab al-Mahmasani, *Falsafat Al-Tashri Fi al-Islam = the Philosophy of Jurisprudence in Islam,* trans. Farhat Jacob Ziadeh (Leiden: Brill, 1961); Kamali, *Principles of Islamic Jurisprudence.*

12 Ahmad al-Raysuni, *Imam Al-Shatibi's Theory of the Higher Objectives and Intents of Islamic Law,* translated by Nancy N. Roberts, abridged by Alison Lake (Herndon, VA: International Institute of Islamic Thought, 2013).

13 Tariq Ramadan, *Radical Reform: Islamic Ethics and Liberation* (Oxford: Oxford University Press, 2009); Auda, *Maqasid al-shari`ah*; al-Raysuni, *Imam Al-Shatibi's Theory of the Higher Objectives and Intents of Islamic Law.*

14 Al-Raysuni, *Imam Al-Shatibi's Theory of the Higher Objectives and Intents of Islamic Law,* 284.

15 Shatibi, *The Reconciliation of the Fundamentals of Islamic Law,* 9.

16 Ibid., 10.

17 Al-Raysuni, *Imam Al-Shatibi's Theory of the Higher Objectives and Intents of Islamic Law.*

18 Shatibi, *The Reconciliation of the Fundamentals of Islamic Law,* 319.

19 Ibid., 14.

20 Ibid.

21 Attia, *Towards Realization of the Higher Intents of Islamic Law.*

22 Ibid.; al-Raysuni, *Imam Al-Shatibi's Theory of the Higher Objectives and Intents of Islamic Law.*

23 Abul Fadl Mohsin Ebrahim, "Vaccination in the Context of Al-Maqasid al-Shari`ah : Objectives of Divine Law and Islamic Medical Jurisprudence," *Arabian Journal of Business and Management Review (Oman Chapter)* 3, no. 9 (May 2014): 44–52; Shaikh Mohd Saifuddeen et al., "Maqasid al-shariah as a Complementary Framework to Conventional Bioethics," *Science and Engineering Ethics* 20, no. 2 (June 2014): 317–27; Omar Hasan Kasule, "Analysis of the Medical Decisions of the International Fiqh Academy from the Perspectives of the Maqasid Al Shari'at and Qawa'id Al Fiqh," *Integrated Medical Education Resources* (blog), 2015, https://omarkasule-tib.blogspot.com/2015/06/150309p-analysis-of-medical-decisions.html; Omar Hasan Kasule, "Understanding Basic Principles of Maqasid Al Shari'at for Healthcare Workers," *Integrated Medical Education Resources* (blog), 2009, https://omarkasule-tib.blogspot.com/2011/07/091018p-understanding-basic-principles.html; Omar Hasan Kasule, "Islamic Medical Ethics with Special Reference to Maqasid al Shari'at," 2007, http://ihcmalaysia.my/index.php/list-of-publications/38-maqasid-syariah; Omar Hasan Kasule, "The Application of Maqasid Al Shari'at in Medical Practice," *Integrated Medical Education Resources* (blog), 2006, https://omarkasule-tib.blogspot.com/2011/05/0609p-application-of-maqasid-al-shariat.html; Bouhedda Ghalia et al., "Medical Ethics in the Light of Maqāṣid al-sharīʿah: A Case Study of Medical Confidentiality," *Intellectual Discourse* 26, no. 1 (June 12, 2018): 133–60; Abdul Halim Ibrahim et al., "Tri-Parent Baby Technology and Preservation of Lineage: An Analysis from the Perspective of Maqasid al-shari'ah Based Islamic Bioethics," *Science and Engineering Ethics* 25, no. 1 (February 2019): 129–42; Abdul Halim Ibrahim, Noor Naemah Abdul Rahman, and Shaikh Mohd Saifuddeen, "Maqasid al-shariah as a Complementary Framework for Conventional Bioethics: Application in Malaysian Assisted Reproductive Technology (ART) Fatwa," *Science and Engineering Ethics* 24, no. 5 (October 2018): 1493–1502.

24 I am aware of such teaching occurring in medical schools throughout Malaysia and more recently in Saudi Arabia.

25 Although there is reference to the *maqāṣid* in many medically-oriented fatāwa, most often reference to the *maqāṣid* is made in order to buttress fiqh-based ethical determinations. Moreover, given the genre, such writings are short and do not provide details on the deliberative frameworks using *maqāṣid.* As such I restricted my sources of study to the extant Islamic bioethics literature in English which provide the space for greater elaboration and represent attempts by Muslim scholars to engage contemporary medical ethics stakeholders.

26 At the same time, since the focus of my study was on scholarly writings that address medical ethics from a *maqāṣidi* perspective the sources I used may not represent

each theoretical model fully. A fuller study is needed to comprehensively review how scholars have built upon al-Shāṭibī's work to furnish newer models of the *maqāṣid al-sharīʿah*.

27 Kasule, "Biomedical Ethics," 39.

28 Ibid.

29 Siti Hafsyah Idris, Abu Bakar Abdul Majeed, and Lee Wei Chang, "Beyond Halal: Maqasid al-Shari'ah to Assess Bioethical Issues Arising from Genetically Modified Crops," *Science and Engineering Ethics* 26, no. 3 (June 2020): 1463–76.

30 Kasule, "Integrated Medical Education Resources."

31 Ibid.

32 Ibid.

33 Ibid.

34 Ibid.

35 Ibid.; Kasule, "Biomedical Ethics"; Saifuddeen et al., "Maqasid al-Shariah as a Complementary Framework to Conventional Bioethics"; Kasule, "Integrated Medical Education Resources."

36 Saifuddeen et al., "Maqasid al-Shariah as a Complementary Framework to Conventional Bioethics," 324.

37 Kasule, "Biomedical Ethics."

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39 Saifuddeen et al., "Maqasid al-shariah as a Complementary Framework to Conventional Bioethics."

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42 Ebrahim, "Vaccination in the Context of Al-Maqasid al-Shari`ah."

43 Ghalia et al., "Medical Ethics in the Light of Maqāṣid al-Sharīʿah."

44 M.M. Nordin, "Immunisation from the Perspective of Maqasid Shariah," *Bangladesh Journal of Medical Science* 15, no. 2 (n.d.): 151–53.

45 Kasule, "Integrated Medical Education Resources," 3.

46 Saifuddeen et al., "Maqasid al-Shariah as a Complementary Framework to Conventional Bioethics"; Kasule, "Integrated Medical Education Resources."

47 Omar Hasan Kasule, "Islamic Medical Ethics with Special Reference to Maqasid al Shari'at," 2007, http://ihcmalaysia.my/index.php/list-of-publications/38-maqasid-syariah.

48 Saifuddeen et al., "Maqasid al-Shariah as a Complementary Framework to Conventional Bioethics."

49 Ebrahim, "Vaccination in the Context of Al-Maqasid al-Shari`ah."

50 Ibrahim, Rahman, and Saifuddeen, "Maqasid al-shariah as a Complementary Framework for Conventional Bioethics," 1496.

51 Ibid.; Ibrahim et al., "Maqasid al-shariah Based Islamic Bioethics"; Ibrahim et al., "Tri-Parent Baby Technology and Preservation of Lineage."

52 Ghaiath Hussein, "What Can Ethics Learn from Islamic Legislation? An Islamic Approach to Moral Analysis Based on the Purposes of Islamic Legislation (Maqsid al-Shariya'a)."

53 Attia, *Towards Realization of the Higher Intents of Islamic Law.*

54 Auda, *Maqasid al-shariah as Philosophy of Islamic Law*; Ramadan, *Radical Reform*; Attia, *Towards Realization of the Higher Intents of Islamic Law*; Y. al-Qaradawi, "Medicine Containing Alcohol for Preservation Purposes.," Halal Industry Development Corporation, accessed 2020, http://www.hdcglobal.com/publisher/pid/219ab653-c702-49b4-8598-ebb11c060596/container//contentId/f7f596a7-b417-4e7d-bdb2-06df1441629e; Yusuf Al-Qaradawi, *The Lawful and the Prohibited in Islam* (Kuala Lumpur: Islamic Book Trust, 2013).

55 Attia, *Towards Realization of the Higher Intents of Islamic Law*, 2007.

56 Ibid.

57 Ibid., 11.

58 Ibid., 195.

59 Ibid., 119

60 Ibid.

61 Ibid., 122.

62 Ibid., 32.

63 Ibid.

64 Ramadan, *Radical Reform*, 142.

65 Ibid., 136.

66 Ibid., 136.

67 Ibid., 138.

68 Ibid., 136.

69 Ibid., 139.

70 Tariq Ramadan, "The Challenges and Future of Applied Islamic Ethics Discourse: A Radical Reform?," *Theoretical Medicine and Bioethics* 34, no. 2 (April 2013): 105–15.

71 Ramadan, *Radical Reform*, 159.

72 Ibid., 176.

73 It is critically important to recognize that al-Shaṭibī's theory is connected to scripture. He uses induction to derive the essential human interests; thus his theory is based on scriptural texts. However this model does not go directly to those scriptural texts.

74 Ebrahim, "Vaccination in the Context of Al-Maqasid al-Shari`ah"; Kamali, *Maqasid al-Shariah, Ijtihad and Civilisational Renewal*; Aasim I. Padela, "The Essential Dimensions of Health According to the Maqasid al-shariʿah Frameworks of Abu Ishaq al-Shatibi and Jamal-al-Din-ʿAtiyah," *IIUM Medical Journal Malaysia* 17, no. 1 (July 2018).

75 Al-Raysuni, *Imam Al-Shatibi's Theory of the Higher Objectives and Intents of Islamic Law.*

76 Nyazee, *Theories of Islamic Law.*

77 Padela, "The Essential Dimensions of Health According to the Maqasid al-Shariʿah Frameworks of Abu Ishaq al-Shatibi and Jamal-al-Din-ʿAtiyah."

78 Aasim I. Padela, "The Perspectives of Islamic Jurists on the Brain Death as Legal Death in Islam," *Journal of Religion and Health* 55, no. 4 (August 2016): 1215–17; Padela, Arozullah, and Moosa, "Brain Death in Islamic Ethico-Legal Deliberation"; Padela, Shanawani, and Arozullah, "Medical Experts & Islamic Scholars Deliberating over Brain Death"; Johannes Grundmann, "Shari`ah, Brain Death, and Organ Transplantation: The Context and Effect of Two Islamic Legal Decisions in the Near and Middle East," *American Journal of Islam and Society* 22, no. 4 (October 1, 2005): 1–25; Birgit Krawietz, "Brain Death and Islamic Traditions: Shifting Borders of Life?," in *Islamic Ethics of Life: Abortion, War, and Euthanasia*, ed. Jonathan E Brockopp (Columbia, SC: University of South Carolina Press, 2003), 194–213; Andrew C. Miller, Amna Ziad-Miller, and Elamin M. Elamin, "Brain Death and Islam," *Chest* 146, no. 4 (October 2014): 1092–1101.

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80 American College of Obstetricians and Gynecologists, "Periviable Birth," 2019, https://www.acog.org/en/clinical/clinical-guidance/obstetric-care-consensus/articles/2017/10/periviable-birth.

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82 On the other hand, if the state was considered to be a dead one, the preservation of life does not apply for the mother. The lower order principles would have to be examined .However sustaining the mother advantages the preservation of life of the fetus, hence once can argue that the preservation of life remains applicable even if the mother is considered to be a dead person.

83 The previous note applies here as well.

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94 Padela, Arozullah, and Moosa, "Brain Death in Islamic Ethico-Legal Deliberation."

95 One could argue that since rulings I quote are about non-pregnant patients who reach the state of brain-dead physiology, they are not applicable; rather, fresh rulings are needed for this scenario. While that might be true, the point is to show that there is some potential dissonance between established *fiqh* and the *maqāṣid*-based medical ethics approaches presented. Proponents may argue that the role of *maqāṣid*-based analysis is to motivate new rulings, and that the dissonance is a positive feature of these medical ethics models. This reasoning does have some merit.

96 Omar Qureshi and Aasim I. Padela, "When Must a Patient Seek Healthcare? Bringing the Perspectives of Islamic Jurists and Clinicians into Dialogue," *Zygon®* 51, no. 3 (September 2016): 592–625; Mohammed Ali Albar, "Seeking Remedy, Abstaining from Therapy and Resuscitation: An Islamic Perspective," *Saudi Journal of Kidney Diseases and Transplantation* 18, no. 4 (2007): 629–37.

97 Aasim I. Padela and Omar Qureshi, "Islamic Perspectives on Clinical Intervention near the End-of-Life: We Can but Must We?," *Medicine, Health Care, and Philosophy* 20, no. 4 (December 2017): 545–59.

98 Attia, *Towards Realization of the Higher Intents of Islamic Law.*

99 Jonathan E. Brockopp, ed., *Islamic Ethics of Life: Abortion, War, and Euthanasia* (Columbia, SC: University of South Carolina Press, 2003); Al-Bar and Chamsi-Pasha, *Contemporary Bioethics.*

100 Daniel Beck, "Between Relativism and Imperialism: Navigating Moral Diversity in Cross-Cultural Bioethics," *Developing World Bioethics* 15, no. 3 (December 2015): 162–71.

101 I am using the term "Islamicize" provocatively in reference to the Islamicization of sciences projects carried out in the last century, and the term "missionary bioethics" refers to how secular forces export values through bioethics work. See Raymond De Vries and Leslie Rott, "Bioethics as Missionary Work: The Export of Western Ethics to Developing Countries," in *Bioethics around the Globe,* ed. Catherine Myser (New York: Oxford University Press, 2011), 3–18.