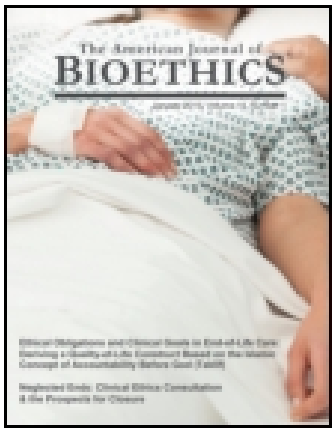

The American Journal of Bioethics
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/uajb20

Exploring a New Concept at the End of Life: Accountability Before God (Mukallaf)

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Published online: 06 Jan 2015.

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Padela and Mohiuddin (2015) have presented an outstanding review of the Islamic concept of end-of-life care.

End-of-life treatment choices are increasing in intensive care units around the world. Many dying patients suffer prolonged and painful deaths, receiving unwarranted, expensive, and invasive care, threatening their physical, psychosocial, and spiritual integrity .Terminally ill patients consume significant resources, including nursing care, transportation, and medications. Padela and Mohiuddin used the theological concept of *mukallaf*, "accountability before God," to qualify for life assessment, assuming that if the patient loses the ability of being *mukallaf* permanently, then the physicians are not obliged to treat such a patient, and hence let him die. This brings forward the question, who is *mukallaf* in the Islamic theology and jurisprudence? The *mukallaf* should be a Muslim competent adult. The age of religious responsibility for both male and female is puberty, which might be as early as 9 years for some girls, and up to 18 years for some boys; the average being 12–15 years. However, the age of social and juristic responsibility is agreed upon as 18 years. The age of discernment and capability of entering financial activities, the so-called (Sin Al Rushed) "age of discernment," may be delayed to 21 years or even more (Auda 1973).

Accordingly, those who are religiously non-*mukallaf* include all non-Muslims, infants and children (prepubertal age), mentally retarded, and permanently mentally disturbed patients. Padela and Mohiuddin limited the meaning of the Qur'anic verse "And I have not created the invisible beings (Jinn) and men to any end other than that may know and worship Me" (51/56). Mohammed Assad in his translation "The Message of the Quran" comments that the innermost purpose of the creation of all rational being is their cognition (*marifah*) of the existence of God and hence their conscious willingness to conform their own existence to whatever they perceive of His will and that gives the deepest meanings to what the Quran describes as worship (*ibadat*) (Assad 1980).

Many scholars such as Malik Ibn Nabi and Mohammed Qutub also object to limiting *Ibada* to the routine performance of Prayers, Fasting, Zakat (Alms giving) and Haj. To them, *Ibada* will involve the role of the man as vice-regent of God on earth. Padela and Mohiuddin limit *mukallaf* to adult competent Muslims, excluding all others.

The second point is the Islamic view on seeking remedy and abstaining from therapy. Seeking remedy in Islamic jurisprudence may be obligatory (mandatory) in certain lifesaving situations, or may be preferred or encouraged (*mandoob*) in other situations. It may be facultative or optional, and may be *makrooh*, that is, not preferred, and in some situations or certain type of treatment it may be *haram*, that is, not allowed.

Seeking remedy is facultative (optional) where benefit is not proved or even doubtful, and where ill effects of that mode of therapy are uncertain. It may be *makrooh* when therapy is unlikely to bring benefit and where harm or even inconvenience from the therapy may exceed its benefit.

Muslim jurists recognize as legal a competent patient's informed refusal of treatment or a living will, which allows a person to die under circumstances in which there are no medical reasons to continue treatment (Albar 2007). The Prophet Muhammad (Peace Be Upon Him) (PBUH) said that seventy thousands would enter paradise without being questioned. When asked who are they, He said, "those who refused Ruqia (Incantation) and treatment" (AlBukhari 1958). In another hadith he lauded the black lady who agreed not to be treated for epilepsy and said if she remains patient she will enter paradise. Many of the *Sahaba* (companions of the Prophet Muhammad) refused to be treated in their final illness. Among them were Abubaker Al Sadiq, Abu Dardaa, Muath Ibn Jabal, and others.

Islam acknowledges that death is an inevitable phase of the life of a human being; medical management should not be given if it only prolongs the final stage of a terminal illness as opposed to treating a superimposed, life threatening condition.

Withholding or withdrawing life support, however, is still an area of controversy. Its applicability is weighed with benefits and risks and how futile the treatment is for the terminally ill patient.

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Terminally ill Muslim patients are permitted to have life-sustaining treatments withheld or withdrawn when the physicians are certain about the inevitability of death and the treatment is futile, does not improve the patient's condition or quality of life, involves great complications, delays the dying process, or involves suffering. However, this should be a collective decision reached on the basis of informed consent after consultation with the patient's family and all individuals involved in providing care. In these situations, death is allowed to take its natural course (Daar 2001).

The definition of "futility" is elusive and has been widely debated. The American Thoracic Society states that a treatment should be considered futile if it is highly unlikely that it will result in "meaningful survival" for the patient. Resource utilization and outcomes in gravely ill patients must be observed. Futile treatments and medical interventions must be considered in light of outcomes.

If the treating physicians find a certain modality of treatment useless or going to increase the suffering of the patient, that modality of treatment should not be enforced from the start. The Prophet Muhammad (PBUH) says, "Above all do no harm," and this rule of nonmaleficence is the cornerstone of all medical ethics. The intention must never be to hasten death, only to abstain from overzealous treatment (Bülow 2008).

Issues arising from the withdrawal and withholding of treatment have not reached total consensus among the Muslim jurists. However, article 63 of the Islamic code of medical ethics can be regarded as a clarion call to Muslim medical personnel. The article stated that "the treatment of a patient can be terminated if a team of medical experts or a medical committee involved in the management of such patient are satisfied that the continuation of treatment would be futile or useless." It further states that "treatment of patients whose condition has been confirmed to be useless by the medical committee should not be commenced" (The Islamic Code of Medical Ethics 2004).

The following *fatwa* is a landmark in regulating resuscitative measures, stopping of machines in cases thought to be not suitable for resuscitative measures. The decision should be based on medical criteria and decided by at least three competent physicians. The family should be approached and the facts discussed fully with them (Albar 2007).

The Permanent Committee for Research and Fatwa in Saudi-Arabia issued Fatwa No. 12086 on 28/3/1409 (1989), which states:

> If the disease is irremediable and patient's death is almost certain, as witnessed by three competent physicians, there is no need to use resuscitative measures, even though the patient or his relatives asked for resuscitative measures to be carried on.
>
> If the patient is mentally or physically incapacitated and is also suffering from stroke or late stage cancer or having severe cardiopulmonary disease or already had several cardiac arrest, and the decision not to resuscitate has been reached by three competent specialist physicians, then it is permissible not to resuscitate.
>
> The opinion of the patient or his relatives should not be considered, both in withholding or withdrawing resuscitative measures and machines, as it is a medical decision and it is not in their capacity to reach such a decision.

According to the *fatwa*, families and guardians cannot decide on the application or removal of resuscitation measures or procedures, as they are not considered qualified under the *fatwa*. This is an important difference from the practice in the United States.

The basic human rights of the patient, which include food, water, nursing, and painkillers, should be provided. The removal of such basic necessities of life will amount to actively killing the patient .The patient should be allowed to die peacefully and comfortably.

At the end of life, the chronic heart patient, for example, often becomes increasingly symptomatic, and may have other life-limiting comorbidities as well. Patients who have an implantable cardioverter defibrillator (ICD) may be denied the chance of a sudden cardiac death, and instead are committed to a slower terminal decline, with frequent electrical shocks that can be painful and decrease the quality of life, greatly contributing to their distress and that of their families during this period. Deactivating an ICD or not performing a generator change is both legal and ethical, and is supported by guidelines from both sides of the Atlantic (Chamsi-Pasha, Chamsi-Pasha, and Albar 2014). This is Islamically acceptable based on the Saudi Ulama Fatwa.

The Islamic Medical Association of North America (IMANA) believes that when death becomes inevitable, as determined by physicians taking care of terminally ill patients, the patient should be allowed to die without unnecessary procedures. It does not believe in prolonging the misery of dying patients who are terminally ill or in a persistent vegetative state (IMANA 2005). ■

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Normativity of Heterogeneity in Clinical Ethics

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End-of-life decisions are among the most important and complex issues in clinical ethics. Over the last two decades, numerous books and articles from secular, Christian, and Jewish perspectives have been dedicated to these problems. However, studies from a Muslim viewpoint have been insufficient, despite urgent demand. Therefore, the article by Padela and Mohiuddin (2015) is a very welcome contribution toward filling this gap.

The authors try to assess medical end-of-life decisions applying the Islamic concept of accountability before God (*Taklif*). Their aim is to provide Muslim doctors with a moral compass for the treatment of Muslim patients at the end of their lives in the framework of a society with pluralistic values. This commentary provides a critical analysis of their approach, weighing up practical merits and ethical problems.

APPLICABILITY OF THE CONCEPT

For the authors, a central criterion for end-of-life decisions is the state of *mukallaf*, meaning that the Muslim person's health permits him or her to fulfill religious duties, characterized by being conscious, possessing mental faculties, and having some degree of physical mobility. Muslim doctors should use this definition as a measure for the Muslim patient's desired quality of life. Medical interventions at the end of life aimed at reaching this state are considered obligatory. If the state of *mukallaf* cannot be reached, withholding and withdrawing of treatment are ethically acceptable even if they may lead to the patient's death.

For the physician in charge, the characteristics of the state of *mukallaf* just described are easy to ascertain and to include into the decision-making process, without requiring any specific ethical, theological, or philosophical training. This feature can be counted as an advantage regarding practical applicability, even though it can be rightly pointed out that an exact prognosis for the outcome of medical interventions is not always achievable—a limitation resulting from the nature of medical intervention as such, rather than from the proposed approach.

Alongside the mentioned strength of the approach, however, Padela and Mohiuddin's suggestion entails a number of problems at ethically different levels. These issues are next addressed from two qualitatively different perspectives: first, ethical aspects arising from the application of this approach in a pluralistic society, and second, methodological problems in reaching an ethical verdict.

NORMATIVE IMPLICATIONS OF HETEROGENEITY

Right at the beginning of their article, the authors mention the heterogeneity of the Muslim community in the United States. Unfortunately, the normative implications of this heterogeneity are not further addressed, especially not with regard to the proposed approach, thus crucially affecting its ethical validity, when the authors assert that "Islamic values influence Muslim physicians." This somewhat vague statement is based upon a study by Padela et al. (2008), who interviewed 10 Muslim physicians, not claiming to have used a representative sample.

Criteria to assess the quality of life are always subjective and attain their ethical importance only through acceptance on the side of the affected subject, which is of course true for Muslim patients, too. By proposing to apply their approach to every Muslim unable to consent as a morally legitimate basis for Muslim physicians' decision making at the end of their patients' lives, Padela and Mohiuddin do not take this ethically important aspect into account.

Moral heterogeneity among Muslims entails two aspects of relevance to the successful implementation of

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