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Rulings on treatment from incurable diseases

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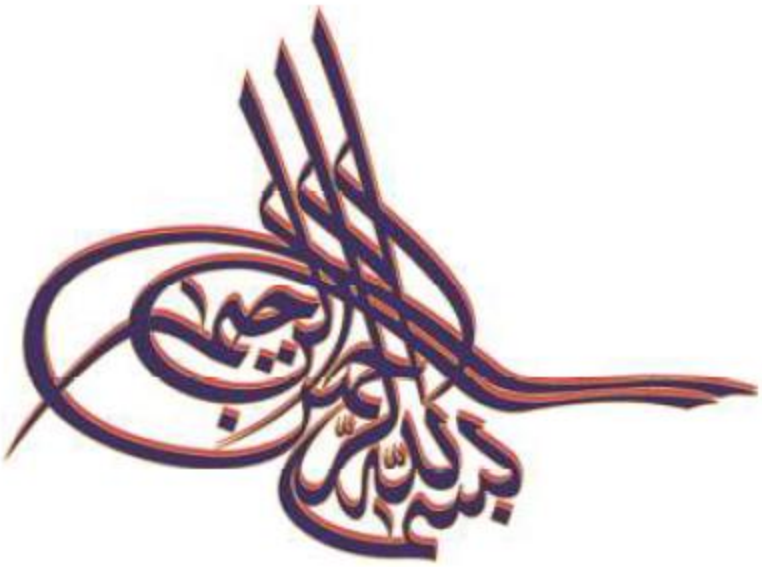
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1. INTRODUCTION

Allah, the Almighty, has willed both illness and remedy as part of his decree. As such, the rulings on disease and treatment are considered an essential part of Islamic law. Scholars have made considerable effort throughout the history to illustrate these rulings.

The advancement of technology has resulted in diagnosing mores diseases. Allah has allowed people to advance in medical knowledge and discover new treatments and methods of life support. Nevertheless, many diseases remain refractory to known therapeutic models. The use of treatment and, in some cases, life-support has become a test to patients, their families and healthcare workers and has had serious social, financial and legal implications for both the individual and society.

Therefore, it is incumbent on scholars to clearly explain rulings on treatment in refractory diseases to remove all doubt, confusion or misunderstanding.

2. GENERAL JURISPRUDENTIAL RULINGS OF TREATMENT

2.1. Permissibility of treatment.

Sharia laws aim to maximize benefits and minimize haram. One of the main goals of sharia laws is to preserve human life. Treatment of illnesses is clearly tied to life preservation. In Islamic laws, the means take the same ruling and positions as their aims. As such, all means of preserving lives are as important as the goal itself. The Quran and the Sunnah have abundant evidence to support this concept. The Quran states: "He makes lawful for them the good things and prohibits for them the evil" [Al-Araf: 157]. The Prophet (peace be upon him) (PBUH), has said: "Allah has sent the illness and the remedy and made a remedy for each illness, so seek remedy and do not use what is prohibited as a remedy".[1]

2.2. Permissibility of abstaining from treatment.

Evidence to support this concept is found in the hadith of the Prophet (PBUH):

> "Seventy thousand nations will enter paradise without reckoning. It was asked: Who are they, O prophet of Allah? He answered: Those who do not use omens, are not pessimists, do not use cautery, but rely on their lord".[2]

1 Narrated by Abu Dawud, a Sahih hadith, No. 3874.
2 Narrated by Muslim, a Sahih hadith, No. 218.

In a different hadith, he said: "Whosever seeks omens or uses cautery then has abandoned reliance [on God]".[3] The Prophet (PBUH) himself cauterized Ubai on his vein during the battalion of Ahzab.[4] This indicated that cautery was a known remedy but the Prophet (PBUH) discouraged its use.

It is also reported that

> "a woman came to the Prophet (PBUH) and mentioned to him that she would have epileptic spells that would expose her body and asked for his prayers. He answered: "you may remain patient and you will get paradise in return or I may ask Allah to heal you". She answered she would remain patient but asked for his prayers so that she wouldn't be exposed so he did".[5]

Ibn Hajar[6] commented on this hadith in his famous book "Fathul-Bari" by saying,

> " the virtue of patience with epilepsy and that patience on world tests leads to paradise, and that being tough is better than taking easement for those who themselves must endure toughness without wavering, and it also has an evidence of permissibility of abandoning remedy".[7]

This is a very strong evidence of abstaining from remedy, knowing the absence of treatment of epilepsy may cause death.

In addition, it is reported that,

> "fever asked the permission of the prophet (PBUH) [to enter] so he asked who it was and she answered "Um Mildam"[8]. He ordered it out to Quba'. The people of Quba' suffered what God knows so they came and complained to the prophet (PBUH). He answered: "Whatever you like? If you like I can pray for you and Allah would take it away or you remain patient and it would be a purification for you". They asked that he would leave it".[9]

This hadith bears a strong evidence of the virtue of enduring disease even when a cure can be certainly attained.

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3 Narrated by At-Tirmidhi. A Sahih Hasan hadith, No. 2055.
4 Narrated by Muslim, a Sahih hadith, No. 2207.
5 Narrated by Bukhari, a Sahih hadith, No. 5328.
6 Ahmad bin Hajar Al-Asqalani, was born and died in Egypt (773-852 H).
7 Ibn Hajar, Fathul-Bari, p 121.
8 The name of fever.
9 Narrated by Ahmad, a Sahih hadith, No. 14393.

The above evidence have made it clear, when it comes to jurisprudence, abstaining from treatment is absolutely permissible.

Scholars stated: "…Engaging in remedies is OK as long as the belief is maintained that

Allah is the Healer and that He decreed the remedy. But if it is believed that the remedy is the healer then it is not OK…[10]

Scholars also stated,

> "…The means to remove harm could be certain such as water would remove the harm of thirst and bread would remove the harm of hunger, plausible such as blood-letting, phlebotomy, taking cathartics and all medical remedies, and illusioned such as cautery and omens. Whatever is certain then abstaining from it is not part of the reliance on God but to the contrary is unlawful if death is feared. Whatever is elusive then abandoning it is that condition to achieve reliance on God as the Prophet stated that. The practice of the middle category, which is the plausible means such medical remedies, is not contradictory to reliance as in the case of the illusioned ones, and its abandonment is not impermissible as it is not the certain ones. It could be better to do in certain cases and better not to in others, so it is in the middle in between the two levels of certain and illusioned ones…[11] it is also stated that "if a sick person was told by a physician to do certain things to be cured but he didn't and ended dying, he would no be sinful if he never believed the treatment were a certain cure".[12]

In summary, abundant, strong evidence exists to support the permissibility of abstaining from treatment of illness.

2.3. Rulings on Treatment According to Different Schools of Thought

2.3.1. Variant opinions.

a. Hanafi: seeking treatment is permissible so long as the belief is maintained that Allah is the Healer.[13]

b. Maliki: seeking treatment is neutrally permissible. Imam Malik[14] is reported to have said regarding treatment "its practice or not are equally acceptable". [15]

10 Indian Fatwas, 5/354.
11 Ibn Tajuddin Al-Hanafi, Ahkamul Mardha, p 355.
12 Above reference.
13 See number 14.
14 Malik ibn Anas, founder of Maliki Math-hab, born and died in Madinha (93-179 H).
15 Ibn Muflih, Al-Adab As-Shari'yah, p. 359.

c. Shafi: seeking treatment is a sunnah that is recommended and encouraged as stated by Imam Nawawi.[16]-[17]

d. Hanbali: seeking treatment, though permissible, is disliked and it is better to avoid it. Ibn Muflih cited "treatment is permissible and avoiding it is better". [18] Ibn Taymiyyah[19] concluded that it could be forbidden, disliked, permissible, recommended or mandatory such as when it is known that preserving life is dependent on a certain remedy, an example of which is eating the dead animal in time of necessity.[20] This opinion is very close to contemporary ijtihad and serves as a moderate and practical opinion that fits current needs.

e. Contemporary opinions: The Islamic Fiqh Council, 7th Convention- 2007[21] concluded the following regarding the ruling of treatment: … it [treatment] is essentially permissible as evident by Quranic texts and oral and practical sunnah traditions and due to the fact that it is consistent with shari'ah aim to preserve life. The level of ruling varies based on person and circumstances and may be detailed as:

1) Mandatory if its avoidance would lead to death, organ damage or disability or if the disease can harm others such as in contagious diseases.
2) Recommended if avoiding it would lead to physical weakness but not to harms as mentioned in #1.
3) Permissible when does not meet criteria of # 1 and 2.
4) Disliked if it done by means that would lead to complication worse than the original illness.

2.3.2. Chosen opinion.

It is not surprising the traditional schools of thought have mainly chosen light rulings regarding treatments, given their tendency to endure difficulty in addition to a lack of developed systematic treatment options during the early days of the development of jurisprudential rulings. In modern times, however, seeking medical treatment has become a cardinal aspect of people's life, consistent with shari'ah's aim to preserve life. With that said, this study inclines to toward the position of contemporary opinions with some modifications detailed below. This is position is similar to the opinion cited by Ibn Taymiyyah.

This study concluded the rulings on treatment should be further deciphered based on providing treatment or seeking treatment as follows:

16 Yahya bin Sharaf An-Nawawi, born in died in Nawa of Syria (631-676 H).
17 Ar-Ramli, Nihaytul-Muhtaj, p. 219.
18 Ibn Muflih, Al-Adab As-Shari'yah, p. 358.
19 Ahmad Abulhalim, born in Harran and died in Damascus (661-728 H).
20 Ibn Taymiyyah, Majmu' Fatawa, v. 21, p. 564.
21 https://www.ar.themwl.org/node/130

a. For authorities: the practice of medicine in shari'ah is a communal obligation. In the present time, providing healthcare has become a right for citizens most governments secure. This study concludes the ruling of treatment on authorities is mandatory and is fulfilled by designated institutions that carry out this responsibility.

b. For health-care workers: the ruling of treatment as it relates to physicians and other members of the healthcare team may be detailed as follows:

1) Obligation to treat contagious or harmful diseases, whose harm extends beyond the affected individual

2) Obligation to treat any person with impending threat to life or organs so long as the benefits of treatment are thought to outweigh the risks.

3) Recommended to treat non-life-threatening illnesses while physicians are available to do so.

4) Disliked to carry out treatment if it is thought to have more harm than benefit.

5) Disliked to treat patients without their permission, except in cases where treatment is mandatory as described above.

6) Forbidden to use prohibited treatment or those measures with more harm than benefit, while alternatives are available.

7) It is permissible for a physician to abstain from treatment when it is believed harms of treatment outweigh benefits.

8) It is permissible for a physician to proceed with treatment when it is believed harm from treatment outweighs benefits, in the case a patient and/or family insist and would take responsibility of medical outcome and financial implications.

c. For patients and their families:

1) It mandatory for a person to accept treatment if it would prevent life loss, prevent organ damage or disability, or would cause harm to others if treatment not received.

2) It is recommended if avoiding treatment would lead to physical weakness but would not result in the harms mentioned in #1.

3) It is permissible when treatment does not meet the criteria of # 1 and 2.

4) It is disliked if treatment is believed to have more harm than benefit as when it is feared to cause worse side effects than the illness itself or would result in wasting money would negatively impact the rights of household when the possibility of a cure is negligible.

5) It is forbidden if the treatment itself is prohibited such as using alcohol or when it is permissible by itself but used for impermissible reasons such as not medically indicated plastic surgeries.

2.4. Rulings of abstinence from treatment.

With the rulings of treatment clarified, the rulings of abstinence from treatment are easily concluded as follows:

1) Forbidden if treatment is known lead to organ damage or disability or would extend harm to others.
2) Disliked when the benefit of treatment outweighs the risks.
3) Permissible when the benefit and harm are equal and there is no way to determine if benefit outweighs the risk.
4) Recommended when the odds for benefits are negligible and the patient might undergo forbidden treatments.
5) Mandatory when treatment is forbidden by itself or done for an invalid reasons.

2.5. Doctor-Patient Relationship

2.5.2. Contractual relationship.

There is not in the traditional fiqh literature a special contract to regulate the relationship between doctors and patients. This contract is in current time is referred to as a "medical contract". However, this study proposes to be more specific with the naming as a contract of "istitbab", which means "seeking medical care" in line with other contract such as "isti'jar"[22] and "istisna"[23]. This terminology approach is more indicative of the meaning and spirit of this contract. This contract is an agreement between the physician and the patient in the same spirit as a hiring contract, by which the doctor provided medical service to the patient according the rules and regulations accepted by the medical community. The doctor is compensated directly by the patient or through another proxy such as insurance companies, the hospital or other entities that fulfill that role. This contract is subject to all the rules of a hiring contract.

2.5.2. Medical consent.

The general permission in its jurisprudential concept is allowing an individual to perform action not allowed to him otherwise.[24] In the case of medical permission it is allowing the doctor and his/her designees to perform medical services unto the patient as the contractual relationship between the doctor and patient mandates the mutual agreement to terms and needs of providing the medical services. The patient's permission is what is known as "consent".

22 Lease contract.
23 Manufacturing contract.
24 Sultanul-Ulama, Ahkam ithn al-insan, v.1, p.37.

The tenants of medical consent consist of the grantor (the patient), the grantee (the doctor) and his/her proxies, as well as the subject (specified medical services) and, finally, the contract language whether verbal, written or shared using sign language.
The validity of medical consent depends on the competency of the patient. The competency is contingent on sanity and adulthood. The subject of the consent has to lawful and well defined. The later provision is the premise upon which this research builds the concept of advance directives, living wills and other related concepts.

2.5.3. Medical consent complements.

a. Advance directives: They may be adapted as advance consent in which the patient dictates his/her desires regarding medical services, upon losing decision-making capacity. As such, advance directives are a valid "permission" Islamically and could be provided verbally or in-writing, but it is preferred they are documented in writing with two witnesses as done in financial transactions and other contracts.

b. Living will: The will technically means the document that serves to execute a person's preferences after death. A living will serves as a document to acknowledge a person's desires while alive but unable to express desires. Therefore, it is similar in concept to advance directs and is a valid option Islamically.

c. Medical power of attorney: This document designates a person as a proxy to make medical decisions on the patient's behalf, upon the patient losing the ability to make decisions directly and give consent, due to a temporary state such as transient loss of consciousness or more prolonged states such as coma. The proxy is given the legal power to make decisions based on their understanding of the patient's desires or what is in the best interest of the patient. This option is accepted by extrapolating the general proxy concept, which is valid in all school of thoughts. Executing decisions of the proxy, however, is contingent on what's in the best interest of the patient as dictated by common knowledge.

2.5.4. Inability of the patient to consent.

It is the patients' right not to be subject to battery by having anything done to them without their consent. However, in certain states, a patient may not be capable of providing consent, due to states of loss of consciousness, or similar conditions. When this condition arises, two situations are presented:

d. An emergency situation where the patient's life or wellbeing is threatened and there is no time to wait for the patient to regain consciousness. In this situation patient permission is not required.

e. The patient is unable to give permission but there is no direct threat to well-being such as in a chronic state of coma. In this case, advance directives or a proxy with power of attorney should be consulted. In the absence of these alternatives, the decision is ascribed to the guardian.[25] If there is a conflict between the Islamic and legal guardianship rules it can be resolved by providing verbal or written proxy by the Islamic guardian to the legal guardian or vice versa. When there is disagreement, the legal guardian takes precedence.

2.6. Practical Rulings on Abstinence form Treatment

2.6.2. Refractory illnesses

Refractory illnesses are defined as those with poor prognosis, i.e. the hope of a cure is negligible. Treating refractory illness is subject to the balance of benefits and risks. Palliative treatments that would absolutely benefit the patient such as pain relief and nursing care would take the ruling of obligation. The treatments that are known to have no benefit, would have complications that would increase the patient's suffering, or would consume resources without certain benefit are considered disliked and may even become forbidden.

2.6.3. Resuscitation

Resuscitation is a series of emergency measures taken to rescue the life of a person who is unconscious. Usually it is referred to as cardiopulmonary resuscitation (CPR) provided to people with breathing or heart arrest or cardiopulmonary arrest.[26] CPR consists of artificial breathing and compressions of the patient's chest. Related to CPR is delivering electrical "shocks" to the heart by means of a device called a defibrillator, which has become available in public places. Usually artificial breathing is completed by passing a tube down the air pipe in a process called intubation. The patient might need to be put on a machine called a ventilator to help with artificial breathing, which is maintained in the intensive care unit. Other therapies may include different medications and, potentially, other complex devices. The above measures, necessary to maintain the life of the patient, are called "life support". The most important practical goal of life support is to preserve the brain tissue intact as much as possible. Cardiopulmonary arrest results in oxygen supply interruption. The longer this interruption lasts, the more brain damage occurs worsening the patient's outcome.

a. Ruling on the order of "Do Not Attempt Resuscitation (DNAR/ DNR)"

25 According to Hanafi and Maliki the order is sonship then fatherhood then brotherhood. According to Shafi' the order is fatherhood then brotherhood then sonship. According to Hanbali the order is fatherhood then sonship then brotherhood. For more details, see Kuwaiti Fiqh Encyclopedia, v.41, p.275-280.

26 Thyegerson: *Advanced First Aid, CPR, and AED.* Jones & Bartlett Learning; 7 edition (May 9, 2016).

This concept means to initiate the resuscitation process in the first place. It could be determined by the patient through advance directives, patient's proxy or by the medical team. Usually, the patient's medical record is labeled with "DNR" so the decision is respected and followed.[27]

The ruling on DNR is simple, once it is understood that the resuscitation process is a type of treatment and is subject to the same rulings of treatment. The specific ruling is based on the calculation of the benefits and risks of resuscitation. As such this research will list its detailed conclusions but before that it is beneficial to cite this credible edict by the Council of Research and Fatwa of Saudi Arabia[28]:

- No need to use resuscitation devices, if the patient arrives to the hospital dead.
- No need to use resuscitation devices if the patient's condition is not suitable for resuscitation, as determined by three credible specialist doctors.
- No need to use resuscitation devices, if the illness is refractory and deemed incurable as determined by three credible specialist doctors.
- No need to use resuscitation devices, if the patient is in a state of incapacitation or stupor associated with chronic illness or advanced cancer with repeated cardiopulmonary arrest, as determined by three credible specialist doctors.
- No need to use resuscitation devices if the patient has brain damage [refractory to treatment], as determined by three credible specialist doctors, due to lack of benefit.
- No need to use resuscitation devices if the cardiopulmonary support is futile and suited for a special situation as determined by three credible specialist doctors, in which case the opinion of the patient's guardians regarding initiating support devices is not considered since this matter is not of their specialty…

This research concluded the following rulings on DNR:

1) It is permissible for a person to elect advance DNR and authorize the physician to make the best decision in light of the benefits and risks considerations.
2) If a person's DNR status is unknown and there has been a loss of consciousness, it is obligatory to resuscitate that person. This is a communal obligation and is more emphasized for capable healthcare workers and particularly doctors.
3) The DNR status elected by a patient should be respected unless the doctor assesses the patient's interest is otherwise. An example of this is when the patient has a stable

27 American Medical Association: *Code of Medical Ethics of the American Medical Association*, 1st Edition.
28 Council of Research and Fatwa of Saudi Arabia, Fatwa N. 12086, p. 322-324.

refractory illness and had what is thought to be transient reversible cardiopulmonary arrest. Of course, there is no issue in following the patient's DNR order.

4) If the patient has not decided the DNR status, then the patient's proxy may make that decision when feasible. If not feasible, the doctor may make the decision, based on the common enacted medical regulations. If there is doubt, the doctor should err on the safe side by not electing DNR, unless three credible doctors deem resuscitation to be futile.

5) In the case of dispute between the patient's proxy and the doctor, the proxy's decision takes precedence, if the proxy agrees to take financial responsibility. Otherwise the doctor's decision takes precedence, if supported by two more doctors.

b. Ruling on withdrawal of life support measures.

As mentioned before, life support measures mean all therapeutic measures used to preserve the vital functions of the patient. They differ according to the patient's condition and may include the "ventilator", heart function devices, the dialysis machine, or pharmaceutical preparations that maintain the stability of the heart and circulation in a way that ensures the continuity of the body's functions.

The issue here is related to stopping or "withdrawing" life support measures and not restarting them, as in the aforementioned issue. This scenario is likely in practice when the patient reaches a stage where the life support measures are considered futile. In this case, the ruling regarding the treatment with respect to the doctor is not obligatory. Rather it may become disliked if the treatments are thought to hurt the patient or waste money and resources without benefit. The ruling may reach the level of prohibition in certain situations such as if there is another patient who needs an intensive care bed or the life-support devices (such as the ventilator) and who is thought to benefit from life support. As for the ruling of treatment with respect to the patient's guardian, it is permissible. If there is a consensus between the medical team and the patient's proxy to stop treatment, the matter will be resolved. If there is a difference between the view of the medical team on the one hand and the patient and his proxy on the other hand, the opinion of the medical team supersedes, so long as three credible physicians agree. We propose that the three physicians are experts in the field and represent three different disciplines such as intensive care, neurology and another independent physician.

It is also important for a mechanism to be in place to resolve dispute that may ensue between the healthcare team and the patient's representatives. It is recommended that an independent committee takes that role and is afforded the permission to verify the diagnosis, validity of treatment, accuracy of prognosis, absence of medical errors at the hands of the doctors and absence of conflict of interest.

2.6.4. Artificial Nutrition and Hydration (ANH)

a. Meaning of ANH. Artificial nutrition is the therapeutic means by which food is delivered to the body of a patient who is unable to eat from the usual natural way i.e. the mouth, and with its natural physiological mechanism which is swallowing. Hydration is the delivery of liquids, in particular. ANH may be delivered through the digestive tract through the gastric nasal tube (NGT) or the gastric tube penetrating the abdominal wall. It may be an intravenous route, where fluids and food are passed through a vein. The basic principle in ANH is that it is temporary, until the natural route is able to be used. However, it has become customary to rely on it for long periods that may extend to years, and herein lies the problem. ANH differs from natural eating in many ways. The purpose of the first is to provide the necessary energy to the patient while eating food in its natural states goes beyond that of pleasure and enjoyment of smelling, looking, tasting, feeling of satiety, people with companionship and others. Indeed, artificial feeding may be a nuisance to the patient because of the tube that enters the nose or penetrates the stomach. There is no place to reconcile artificial nutrition with naturalism. ANH requires the patient to undergo the procedure of placing the method of feeding, which in itself is a process not without harm and pain, with the associated potential for complications and side effects of surgical intervention. Among the most important reasons for insisting on ANH are non-medical purposes, such as a feeling of compassion for the patient and a feeling of performing his duty towards him in terms of fulfilling his right to nutrition, and preventing the patient from falling into thirst and desire and the resulting pain and suffering. Therefore, it must be emphasized that most dying patients do not feel hunger or thirst, nor is their need for ANR temporary. It is not effective for intravenous fluids to prevent thirst or hunger.[29-30] The truth is that when a patient stops eating, it is due to the body's inability to process food. ANH methods may cause side effects such as nausea, flatulence and diarrhea.
b. Ruling on ANH. It is evident from the above that ANH is a treatment method that entails a set of benefits and risks. Ruling on ANH should not be isolated from the patient's general condition. The rulings on treatment in its five different levels applies to ANH including abstinence from it in the form of not initiating it or its withdrawal when it's futile. It should be emphasized that when futile, not initiating ANH is in the first place is better than resorting to its withdrawal. Finally, the patient's symptoms must be treated including pain by using different palliative therapies.

29 McCann, Hall, Groth-Juncker: Comfort care for terminally ill patients. The appropriate use of nutrition and hydration, JAMA, 272(16):1263-6.
30 Musgrave, Bartal, Opstad: The sensation of thirst in dying patients receiving i.v. hydration, J Palliat Care, 11(4):17-21.

3. CONCLUSION

1. The ruling on treatment ranges between the five known different levels of rulings and is determined by the assessment of benefits and risks.
2. The doctor-patient relationship is adapted Islamically by contractual relationship, which entails mutual agreements and the patient's permission for the medical service.
3. The permission concept allows for the adoption of many practices including medical consent, advance directives, living will and medical power of attorney.
4. "DNR" is a valid practice.
5. It is permissible to withdraw life support measures when they become futile.
6. ANH is a type of treatment and its use is subject to the assessment of benefits and risks. The rulings on treatments apply to ANH including abstinence in the form of not initiating it or its withdrawal when futile.

4. RECOMMENDATIONS

1. To dedicate special section in fiqh books for medical issues.
2. To advise people to include their preferences regarding end-of-life issues in their wills.
3. To form a medical council on medical fiqh.

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