The American Journal of Bioethics

Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/uajb20

Normativity of Heterogeneity in Clinical Ethics

Ilhan Ilkilic

Istanbul University Faculty of Medicine

Published online: 06 Jan 2015.

To cite this article: Ilhan Ilkilic (2015) Normativity of Heterogeneity in Clinical Ethics, The American Journal of Bioethics, 15:1, 21-23, DOI: 10.1080/15265161.2014.974781

To link to this article: http://dx.doi.org/10.1080/15265161.2014.974781

PLEASE SCROLL DOWN FOR ARTICLE

Taylor & Francis makes every effort to ensure the accuracy of all the information (the “Content”) contained in the publications on our platform. However, Taylor & Francis, our agents, and our licensors make no representations or warranties whatsoever as to the accuracy, completeness, or suitability for any purpose of the Content. Any opinions and views expressed in this publication are the opinions and views of the authors, and are not the views of or endorsed by Taylor & Francis. The accuracy of the Content should not be relied upon and should be independently verified with primary sources of information. Taylor and Francis shall not be liable for any losses, actions, claims, proceedings, demands, costs, expenses, damages, and other liabilities whatsoever or howsoever caused arising directly or indirectly in connection with, in relation to or arising out of the use of the Content.

This article may be used for research, teaching, and private study purposes. Any substantial or systematic reproduction, redistribution, reselling, loan, sub-licensing, systematic supply, or distribution in any form to anyone is expressly forbidden. Terms & Conditions of access and use can be found at http://www.tandfonline.com/page/terms-and-conditions
Normativity of Heterogeneity in Clinical Ethics

Ilhan Ilkilic, Istanbul University Faculty of Medicine

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 (Tallahf). 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
the proposed concept: First, there is a broad spectrum of religiosity, from strictly observant and devout individuals to a nonreligious, secular attitude and lifestyle. Second, even between Muslims who consider themselves pious and devout, there are different positions toward ethical questions regarding the end of their lives. Both kinds of heterogeneity are important for the proposed approach, as we point out in more detail next.

Padela and Mohiuddin do not distinguish between Muslim patients professing different intensities of religious commitment; if unable to consent, their doctors should treat all of them with the aim to reach a state of mukallaf. If, however, a secular Muslim does not value this particular state, he or she may be treated against his or her interest and value system. Given that the proposed concept does not envisage any other outcome for Muslims unable to consent, it does not seem to do justice to heterogeneity.

Another type of heterogeneity, between different forms of religiosity correlating to divergent ethical assessments of medical interventions at the end of life, is also relevant for the implementation of the proposed approach. Within the Islamic world, we inevitably find a plethora of divergent positions toward individual issues (Atighetchi 2007; Sachedina 2009). While the article mentions Shia opposition to withholding and withdrawing treatment at the end of life, the authors present Sunni opinions as homogeneous and affirmative: “Sunni Islamic jurists routinely allow for the withdrawal of life support when certain clinical parameters are met” (6). However, as a detailed analysis of the academic literature discussing this issue shows, there is no homogeneity within the Sunni world regarding withdrawal of therapy (Atighetchi 2007, 267 et passim; Bardakoglu 2004; Sachedina 2009, 145 et passim; Van den Branden and Broeckaert 2011, 34).

This commentary does not attempt to choose a preferred position on the basis of fundamental Islamic sources. Rather, it argues for a serious consideration of existing differences in opinion and for an ethnically adequate implementation in clinical practice, to avoid resulting in a patient who cannot consent but does not share the basic assumptions of the reviewed approach to be treated against that patient’s interest and values. An approach, even if based on Islamic sources, that is unable to accommodate divergent opinions from within the Islamic world is not uncritically applicable to an entire Muslim community.

CASUISTIC VERSUS NORMATIVE METHODOLOGY

Responsibility before God for our actions is the central concern of any moral theology within monotheistic religions. Islamic jurisprudence, too, considers this good to be the aim of Muslims’ actions. Over time, specific methods and concepts have been developed to implement these values in practice. This process often involves the appeal to precedents, constituting a casuistic way of decision making, as is the case with the proposed approach. This casuistic method, however, is becoming increasingly problematic when addressing complex contemporary bioethical problems such as human cloning, stem-cell research, organ transplantation, brain death, and so on. These thematic areas include the end of human life and ensuing ethical questions. Why should we employ a normative approach to these problems rather than casuistic decision making?

By accepting the absence of specific faculties and capacities as an Islamically acceptable justification for the termination of medical interventions, Padela and Mohiuddin are incurring the danger that these faculties may be used by a third party, the Muslim doctor, to judge life—even if that may not be the authors’ intention. To prevent such a problematic judgment, arguments should be derived from an Islamic conception of humanity, life, and death (Ilkilic 2014). This procedure requires normative arguments from Islamic anthropology and philosophy, not restricted to casuistry.

The authors acknowledge this issue: “Another ethical framework needs to be developed for considering the Islamic bioethical perspective on the initiation or abatement of clinical treatment at the end-of-life for such persons [i.e., non-mukallaf individuals]” (Padela and Mohiuddin 2015, 8). Ethically and practically, however, it does not seem appropriate to draw up a new ethical framework for every single human situation. If we are to overcome this dilemma, we need a normatively consistent approach based on philosophical and anthropological premises from Islamic tradition to govern clinical practice and address complex issues in modern bioethics.

CONCLUSION

An approach to clinical ethics based on religious premises not only has to be consistent with the fundamental moral norms of the faith, but also has to accommodate the heterogeneity of the relevant culture, avoiding reducing this heterogeneity to a descriptive dimension, but rather embracing it ethically.

Complex bioethical problems increasingly challenge conventional casuistic decision-making in Islamic jurisprudence. End-of-life decisions in particular should not be based only on criteria of quality of life, but need to take into account normative concepts such as life and death and their intrinsic normative meaning analyzed through Islamic anthropology and philosophy, to avoid undue judgment of human life along inadequate criteria.

REFERENCES

Drs. Padela and Mohiuddin (2015) propose a framework for treatment cessation by Muslim physicians supported by Islamic quality-of-life considerations, interpreted by the authors as the state of the patient’s accountability before God (takliff). In contrast, we argue that concern for a patient’s spiritual well-being does not support attribution of quality-of-life to mukallaf status. We also argue that recognition of clinical uncertainty opposes treatment cessation by Muslim physicians and precludes probabilistic decision making. In so doing, we advocate for Muslim physician, patient, and family decision-making processes to be guided by the Islamic principle of precaution (ihityāt).

The authors first identify that while Sunni Islamic ethical/legal verdicts permit end-of-life treatment cessation both in brain-dead physiology and in “futile” cases, the clinical context and Muslim physician obligations are unclear in the latter. They then identify a mukallaf individual as one who is accountable before God, characterized as able to “perform willful acts while being cognizant of their potential afterlife rewards.” In practice, mukallaf status is valuable for determinations of whether one is accountable for fulfilling Islamic obligations—and earning afterlife rewards. Building upon Rahman’s (1987) belief that in Islam only a life “worth living” merits continued therapy, Padela and Mohiuddin propose mukallaf status as a suitable Islamic quality-of-life metric to guide Muslim physician end-of-life decisions. They argue that if a patient’s clinically determined probability of fulfilling Islamic obligations and earning afterlife rewards is sufficiently low, then continuation of therapy does not offer a life worth living and cessation by a Muslim physician is permissible. The authors’ arguments are certainly attractive in expertly blending secular, medical considerations with Islamic values; however, their model suffers from two serious shortcomings.

For Sunni Muslim physicians, the potential utility of incorporating takliff as an Islamic quality-of-life metric into clinical decisions is that it would answer when cases are “futile,” and thus permitted to have therapy withdrawn. In the case offered of a patient in a persistent vegetative state (PVS), Padela and Mohiuddin believe that the patient now lacks the ability to perform acts benefiting his or her afterlife, which we understand to mean that only detectably cognitive worship yields benefits in the afterlife; however, this assumption can be called into question based on Islamic teachings. While acknowledging one aspect of worship, the patient’s Islamic obligation to fulfill rights of worship, the patient’s Islamic obligation to fulfill rights of worship to the living and the dead, we argue that concern for a patient’s spiritual well-being does not support attribution of quality-of-life to mukallaf status. We also argue that recognition of clinical uncertainty opposes treatment cessation by Muslim physicians and precludes probabilistic decision making. In so doing, we advocate for Muslim physician, patient, and family decision-making processes to be guided by the Islamic principle of precaution (ihityāt).