

Technology at the end of life: “Medical futility” and the Muslim PVS patient

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ABSTRACT

Advanced life-sustaining technologies can now prolong indeterminately the lives of patients in a persistent vegetative state (PVS). However, where the assistance rendered is not expected to restore consciousness, they are considered futile from a medical perspective. English law, in such a scenario, has taken the view that it is not in the best interests of the patient to continue to receive medical intervention. This makes it lawful to discontinue all life-sustaining treatment and medical support measures including the termination of clinically assisted nutrition and hydration (CANH). The withdrawal of such apparatus, which is classified as medical treatment, is deemed as an omission rather than negligence or an act which causes death. In light of this, the law holds that doctors are merely allowing such patients to die a natural death rather than bringing about their death. The medical debate on the matter, which is underpinned by a series of intertwined medico-legal concepts which justify the English Law position, is often considered as settled. The UK Court of Protection was nevertheless recently asked to resolve a conflict between the family of a Muslim PVS patient who objected to his doctors' intention to withhold resuscitation or ventilation should there be a life-threatening event on the grounds that such measures would be futile and thereby not in the patient's best interests. The family instead insisted that all steps should be taken to preserve the patient's life until such time that God takes it away. This paper seeks to discuss how such medical futility or at least the semantic conceptual landscape (which also includes best interests, omissions and medical treatment) that determines the legal position is dealt with under Islamic Law with a view to assess its compatibility with English Law. Some of the key questions that the article will consider as part of the above will be: does Islam allow all medical interventions, including CANH to be withdrawn when these are not expected, by medics, to bring any medical benefit? Or does it instead deem their withdrawal from such patients, who may still be able to breathe naturally, as an activity which is tantamount to killing? The work concludes by emphasizing the need for more religiously and culturally sensitive discussions to take place among medical, legal and religious representatives.

Keywords: persistent vegetative state (PVS), English law, medical futility, Sharia law, end of life

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I. INTRODUCTION

Healthcare in the United Kingdom (UK), as in many other Western countries, is heavily reliant on advanced technology after the Second World War. This ranges from sophisticated medical know-how and devices which assist in the creation of new human lives, to apparatus which help prolong or preserve the lives of those who would otherwise have died just a few decades ago. While all these may have enhanced and/or saved the lives of many, some technological interventions have generated intractable medico-legal dilemmas. One of these relate to patients in a persistent vegetative state (PVS). The perpetuation of their existence “through a merger of body and machine”¹ has given rise to the controversial question as to whether it is appropriate to continue indefinitely life-sustaining measures² since the medical profession is of the view that their prognosis for recovery is generally poor.

English law was first invited to adjudicate on this matter in the early 1990s in the now seminal case of *Airedale NHS Trust v. Bland*.³ The House of Lords, then the highest appellate court in England and Wales,⁴ ruled that once a diagnosis of PVS is confirmed, all life-sustaining treatment and medical support designed to keep the patient alive including clinically assisted nutrition and hydration (CANH) (i.e., the provision of food and water to the patient), could be lawfully withdrawn. This was on the grounds that it would not be in the patient’s best interests to have his life prolonged given that those interventions are considered medically futile. In addition, the withdrawal of all these measures including of CANH, is characterised as a lawful omission of medical treatment rather than the performance of an act which causes the patient’s death. Although two decades have transpired since the ruling was passed, these parameters as set up in *Bland* still govern the legal management of PVS patients in the UK today.

A recent case which came before the Court of Protection in 2012⁵ nevertheless casts doubt on the general acceptability of this conceptual framework among some British Muslims. There, the family of a fifty-five year old Muslim man who was in an apparently vegetative state after suffering a cardiac arrest, objected to an application made by the Pennine Acute Hospitals NHS Trust for a declaration that it would not be in his best interests to be offered ventilation or resuscitation if there was a life-threatening event. The family was vehement that all steps should be taken to preserve life “until God takes it away”.⁶ However, the declaration was granted on the established premise that there would not be any realistic prospect that such treatments could produce any benefit. Given that the ruling implies that the approach espoused in *Bland* is to be applied without adjustments to all Muslim PVS patients in the UK, the natural question that arises is how far are the medico-legal concepts deployed, congruent with Islamic law?⁷ This paper seeks to examine the semantic conceptual landscape which determines the current position under English law and assesses its suitability for the Muslim community in Britain.

The next part of the work takes a close look at the facts of *Bland* and its legal parameters. We then outline their subsequent development in the post Human Rights Act 1998 and Mental Capacity Act 2005 era. It will be shown that far from effecting changes, the courts’ interpretation of these Acts have only served to confirm and crystallise the medico-legal framework established in *Bland*. Part III will then examine whether the *Bland* model which is underpinned by principles like futility, best interests, medical treatment and omission is compatible with Islamic law. To answer this question, the significance of this issue to British Muslims at grass roots level will firstly be highlighted. The work will then provide a general outline of the *Sharia* framework on end of life decision-making before looking at the different variants involved in the management of Muslim PVS patients. It will be argued that Islam takes a fundamentally different perspective on the supposed futility of technological interventions for PVS patients. Viewing every illness or medical condition as a trial from God, and for which the search

¹*Cruzan v. Director, Missouri Department of Health* 110 S.Ct.2841, 2883 (1990).

²Bryan Jennett, *The Vegetative State: Medical Facts, Ethical and Legal Dilemmas*, at ix. (Cambridge: Cambridge University Press, 2002).

³*Airedale NHS Trust v. Bland* 1 All ER 821 (1993).

⁴This court has since been replaced by the UK Supreme Court in 2009.

⁵A similar case concerning a Muslim PVS patient by the name of Hassan Rasouli is currently awaiting the Supreme Court’s ruling in Canada, available at http://www.thestar.com/news/canada/2012/12/10/supreme_court_decision_on_hassan_rasouli_will_clarify_endoflife_medical_decisions.html (last accessed 31 October 2013).

⁶“Judge backs doctors in Muslim man’s right-to-life case”, BBC News 8 October 2012, at <http://www.bbc.co.uk/news/uk-england-19873175> (last accessed 31 October 2013).

⁷Regrettably, this case has not yet been reported at the time of writing. We are therefore unable to access and analyse the legal arguments tendered therein nor examine the ruling issued by Mr Justice Moynihan.

for cure should not cease prematurely, the withdrawal and withholding of medical interventions from those patients are only allowed and thus considered in their best interests where there is robust medical evidence that there is absolutely no hope that they would regain consciousness. In all other circumstances, continuation of the interventions is either mandatory or debatable depending on the patient's ability to breathe independently. Where continuation is mandatory, its cessation would be sinful and is tantamount to murder. It will be shown that Islam also views CANH differently i.e., as basic care rather than medical treatment. This would therefore need to be continually provided even in most circumstances where omission is permissible. Finally, Part IV calls for a way forward that is respectful of the value system and cultural sensitivity of the Muslim community in Britain.

II. THE LEGAL MANAGEMENT OF PVS PATIENTS

The term "vegetative state" first entered the medical lexicon in 1972⁸ to describe a condition of "being awake but unaware with no evidence of a working mind".⁹ This phenomenon resulted from advances in life-sustaining technologies, particularly those associated with resuscitation, intensive care and nourishment, which prevented death from taking place following severe neurological damage to the brain's cerebral hemispheres.¹⁰ This clinical condition is now described by the Royal College of Physicians (RCP) as one of "unawareness of self and environment in which the patient breathes spontaneously, has a stable circulation, and shows cycles of eye closure and opening which may simulate sleep and waking" that has continued for four weeks or more.¹¹ Such patients are deemed as permanently unconscious (i.e., a state known as persistent vegetative state) if they have been in that state for more than six months when the underlying pathology is non-traumatic, or more than twelve months when the underlying pathology is traumatic injury.¹² Notwithstanding their complete non-engagement with their surrounding environment, it is generally agreed that PVS patients are medically and legally still alive, since their brain stems remain functioning.¹³ They are nevertheless wholly dependent on others for their day-to-day care. Not only that, they rely for their survival on nasogastric or gastrostomy tubes for nutrition; percutaneous endoscopic gastrostomy (PEG) tubes for fluids; and catheters and enemas for the excretion of wastes. Some may even need the assistance of mechanical ventilators to breathe.

With such help constantly in place, PVS patients can continue to survive for many years. Indeed, one of the longest known sufferers is Aruna Shanbaug, a nurse from India who is reported to have been in this state for over forty years, since 1973.¹⁴ One of the most high profile sufferers, Ariel Sharon, the former Prime Minister of Israel, too has been in this condition for over seven years at the time of writing, since 2006.¹⁵ At the beginning of 2013, it was reported that he showed significant brain activity when presented with pictures of his family and when doctors had him listen to his son's voice.¹⁶ This development has given rise to hopes that he will one day wake.¹⁷ In general, however, the medical profession has not expressed optimism about vegetative patients' prognosis for regaining consciousness if they are in this condition for over twelve months and especially over forty years of age.¹⁸ Thus, when the media occasionally announces cases of adult PVS patients waking up after being

⁸Andrew Grubb, *et al.*, *Reporting on the Persistent Vegetative State in Europe*, 6(2) *Med. L. Rev.*, 161 (1998).

⁹Bryan Jennett, *supra* n. 2, at ix.

¹⁰*Id.*; Kenneth Mitchell, *et al.*, *Medical Futility, Treatment Withdrawal and the Persistent Vegetative State*, 19 *J. Med. Ethics* 71, 74 (1993).

¹¹Royal College of Physicians, *The Vegetative State: Guidance on Diagnosis and Management*, 1–2 (2003).

¹²*Id.* 5.

¹³See *Diagnosis of Death: Memorandum Issued by the Honorary Secretary of the Conference of Medical Royal Colleges and their Faculties in the United Kingdom on 15 January 1979*, 1 *Brit. Med. J.* 332 (1979); *Re A (A Minor)*, 3 *Med. L. Rev.* 303 (1992); *R v. Malcherek, R v. Steel* 1 *WLR* 690 (1981); Academy of Medical Royal Colleges, *A Code of Practice for the Diagnosis and Confirmation of Death*, 11 (2008).

¹⁴"India Court Rejects Aruna Shanbaug Euthanasia Plea", *BBC News South Asia* 7 March 2011, at <http://www.bbc.co.uk/news/world-south-asia-12662124> (last accessed 31 October 2013).

¹⁵"Ariel Sharon: Israeli Ex-PM in Coma 'Has Brain Activity'" *BBC News Middle East*, 27 Jan. 2013, at <http://www.bbc.co.uk/news/world-middle-east-21225929> (last accessed 31 October 2013).

¹⁶Ashley Fantz & Jethro Mullen, "Significant Brain Activity" in Comatose Ariel Sharon, available at <http://edition.cnn.com/2013/01/28/world/mesat/israel-sharon-brain-activity>, 28 Jan. 2013 (last accessed 31 October 2013).

¹⁷*Id.*

¹⁸The Multi-Society Task Force on PVS, *Medical Aspects of the Persistent Vegetative State* 330 *New Eng. J. of Med.*, 1572 (1994); Cheryl Arenella, *Coma and Persistent Vegetative State: an Exploration of Terms*, available at <http://www.americanhospice.org/articles-mainmenu-8/caregiving-mainmenu-10/50-coma-and-persistent-vegetative-state-an-explorati-on-of-terms> (last accessed 31 October 2013).

in this state for several years,¹⁹ doctors have either explained these as incidents where the initial diagnoses of PVS were mistaken,²⁰ or dismissed them pejoratively as “miracles”.²¹ In all other cases, they claimed that death would eventually occur either through one or a combination of the following: pressure sores, chest infections, pneumonia, deep-vein thrombosis that develops into pulmonary embolus, kidney failure and other related complications.²²

If the medical profession is of the view that the chance of recovery after being in a vegetative state for more than twelve months is remote,²³ should life-sustaining interventions be continued until the patient dies naturally from one or more of those complications? Or, is it legally acceptable to cease and withdraw those interventions before that moment arrives? This article now turns to the House of Lords’ response to these questions in *Airedale NHS Trust v. Bland*.²⁴ It then examines the judicial and statutory developments that have since taken place.

A. Airedale NHS Trust v. Bland

The case of *Airedale NHS Trust v. Bland*²⁵ concerned a football fan by the name of Anthony Bland who was tragically caught in the Hillsborough Football Stadium Disaster on the 15th April 1989.²⁶ His lungs were crushed and punctured, and his brain was starved of oxygen. As a result, he suffered catastrophic and irreversible damage to the higher centres of his brain, which left him in a persistent vegetative state since April 1989. He was then only seventeen years of age. After being in this condition for over three years, and when all the doctors who had been consulted about the case were in agreement that there was no hope of any improvement or recovery, his family and doctors decided that all medical interventions which were sustaining his life should come to an end. The hospital where he was being treated, the Airedale NHS Trust, therefore sought declarations from the court that they might:

“i) lawfully discontinue all life-sustaining treatment and medical support measures designed to keep [him] alive in his existing persistent vegetative state including the termination of ventilation, nutrition and hydration by artificial means; and

ii) lawfully discontinue and thereafter need not furnish medical treatment to [him] except for the sole purpose of enabling [him] to end his life and die peacefully with the greatest dignity and the least of pain, suffering and distress.”²⁷

In granting the declarations, the House of Lords ruled that since the purpose of medical treatment and care was to benefit the patient, the principle of sanctity of life was not violated by the cessation of such interventions even though it would lead to the inevitable death of Anthony Bland within a week or two. It was held that it would not be in his “best interests” to have his life prolonged by the continuance of such forms of treatment and care which were not conferring any therapeutic benefit to him.²⁸ Any interventions were thereby deemed useless and it was the futility of this which was said to justify their termination.²⁹

Given the circumstances, his doctors would no longer be under a duty to treat him where a responsible and competent body of the medical profession agrees with them that no benefit at all is

¹⁹E.g., Terry Wallis (aged 39) who woke up after 19 years; Don Herbert (aged 43) who woke up after 10 years; Christa Lilly (aged 49) who woke up after 6 years; and Evie Branan (aged 79) who woke up after 5 years. See e.g., *The Big Sleep: Terry Wallis*, at http://www.time.com/time/specials/packages/article/0,28804,1864940_1864939_1864908,00.html (last accessed 31 October 2013); *After Decade in Coma, Just 10 Months Awake*, at <http://edition.cnn.com/2006/US/02/21/coma.death/> (last accessed 31 October 2013); *Brief Awakening for US Coma Woman*, at <http://news.bbc.co.uk/1/hi/world/america/6435949.stm> (last accessed 31 October 2013); *Evie Branan, 79, Wakes from 5-Year Coma and Asks to go to Bob Seger Concert*, at http://www.huffingtonpost.com/2013/04/10/evie-branan-bob-seger-coma_n_3047399.html (last accessed 31 October 2013).

²⁰Joseph Fins, *Brain Injury: The Vegetative and Minimally Conscious States*, in Hastings Center, *From Birth to Death and Bench to Clinic: The Hastings Center Bioethics Briefing Book for Journalists, Policymakers, and Campaigns* (New York: The Hastings Center, 2008), 15.

²¹Richard Luscombe, *Awake for Only 12 Days This Century – “Miracle” of Coma Woman*, *The Guardian* 9 March 2007, at <http://www.guardian.co.uk/world/2007/mar/09/usa.hyrichardluscombe> (last accessed 31 October 2013).

²²Peter Alldridge & Derek Morgan, *Ending Life*, 142 *New L. J.*, 1536 (1992).

²³Martin Monti, *The Vegetative State*, 341 *Brit. Med. J.*, c3765 (2010).

²⁴*Airedale NHS Trust v. Bland*, 1 All ER 821 (1993).

²⁵*Id.*

²⁶For detailed information about the incident, see Home Office, “*The Hillsborough Stadium Disaster*”, 15 April 1989, Inquiry by the Rt. Hon. Lord Justice Taylor: Interim Report (1989), at 4–46.

²⁷*Airedale NHS Trust v. Bland*, 1 All ER 821, 822–823.

²⁸*Per* Lord Goff at 868.

²⁹*Id.* 869.

conferred by their continuation.³⁰ This endorsement of the *Bolam* test³¹ as the basis for the decision to discontinue the interventions thereby proclaimed doctors as the determinants of “futility” and renders medical opinion fundamental to determinations of “best interests”.³² Once they have so decided, no crime is committed when they remove all life-sustaining treatment and subsequently withhold further medical support. These would constitute mere “omissions” and are not considered the cause of the patient’s death. Rather, the patient is returned to the position he was in when he was first admitted to hospital and it was his natural condition which led to his death.³³

The House of Lords added that a declaration needs to be sought from the court whenever a doctor decides to withdraw the life-sustaining treatment from a PVS patient in the future. Although this offered a procedural safeguard that could help ensure that such monumental decisions are not the sole province of doctors,³⁴ it would appear that this is but a rubber-stamping exercise by the judiciary.³⁵ As developments in the post-*Bland* era shows, once the doctors have agreed that the treatment is medically futile, judges have not been hesitant to find that withdrawal and withholding of treatment to be in the patient’s best interests, thereby lawful. Thus court approval, though mandatory,³⁶ is nothing more than a mere formality.³⁷

B. Post-*Bland* developments

1. Statute

In the twenty years since the *Bland* ruling was issued, two relevant statutes were passed by Parliament: the Human Rights Act 1998 and the Mental Capacity Act 2005. It will be seen that based on their interpretations by the courts, neither one has made a noticeable difference to the medico-legal framework set up in the case.

The Human Rights Act 1998 came into force in 2000. In *NHS Trust A v. Mrs M, NHS Trust B v. Mrs H*³⁸ and later confirmed in *Re G (adult incompetent: withdrawal of treatment)*³⁹ and *A Hospital v. SW*,⁴⁰ the courts made it clear that the withdrawal of life-sustaining measures from PVS patients, including CANH, is not incompatible with Articles 2 and 3 of the European Convention on Human Rights. As regards Article 2 (the right to life), it was claimed that the analysis in *Bland* was entirely consistent with both the negative and positive obligations embedded within the Article. It was opined that the deprivation of life referred to therein must import a deliberate act, as opposed to an “omission”, by someone acting on behalf of the State which culminates in death. A responsible decision by the medical profession to withdraw or withhold treatment was not therefore considered to be tantamount to an intentional deprivation of life by the State. As regards the State’s positive obligation under the Article to take adequate and appropriate steps to safeguard life, it was averred that this obligation is discharged where the medical profession’s decision to withhold treatment is made: on the grounds that it is not in the patient’s best interests and in accordance with the practice of a respectable body of medical opinion.

³⁰Per Lord Keith at 858–859 and Lord Goff at 870.

³¹I.e., the principle that arose from the case of *Bolam v. Friern Hospital Management Committee* 1 WLR 582 (1957), which states that a doctor is not negligent if he was acting in accordance with a practice accepted as proper by a responsible body of the medical profession.

³²Andrea Fenwick, *Applying Best Interests to Persistent Vegetative State – A Principled Distortion?* 24 J. Med. Ethics 86 at 87 (1998).

³³For a critique of the House of Lords’ reasoning, see e.g., Sheila McLean, *Human Rights and the Patient in a Persistent Vegetative State* 19 Int’l Legal Prac., 19 (1994); John Keown, *The Legal Revolution: from “Sanctity of Life” to “Quality of Life” and “Autonomy”* (1997–1998) 14 J. Contemp. Health L. & Pol’y, 253 (1997–1998); John Harris, *Consent and End of Life Decisions*, 29 J. of M. Ethics 10 (2003); Jenny McEwan, *Murder by Design: the “Feel-Good Factor” and the Criminal Law*, 9(3) Med. L. Rev. 246 (2001).

³⁴Julie Stone, *Withholding Life-Sustaining Treatment: the Ultimate Decision*, 144 New L. J., 205 (1994).

³⁵Kristina Stern, *Withdrawing Medical Treatment and the PVS Patient* (1993–1994) 4 King’s College L. J., 114, 118 (1993–1994); Penney Lewis, *Withdrawal of Treatment from a Patient in a Permanent Vegetative State: Judicial Involvement and Innovative Treatment* 15(3) Med. L. Rev. 392 (2007).

³⁶Practice Note (*Official Solicitor: Declaratory Proceedings: Medical and Welfare Decision for Adults Who Lack Capacity*) 2 FLR 373 (2006).

³⁷Emily Jackson, *The Minimally Conscious State and Treatment Withdrawal: W v. M*, J. of Med. Ethics, doi: 10.1136/medethics-2012-100981 (2012).

³⁸*NHS Trust A v. Mrs M, NHS Trust B v. Mrs H*, 2 WLR 942 (2001).

³⁹*Re G (Adult Incompetent: Withdrawal of Treatment)*, 65 BMLR 6 (2002).

⁴⁰*A Hospital v. SW*, EWHC 425 (Fam) (2007).

The courts similarly held that no contravention of Article 3 (the right not to be subjected to torture or inhuman and degrading treatment) exists. Where it might be argued that death by starvation and dehydration as caused by the withdrawal of CANH is inhuman and degrading,⁴¹ it was asserted that since the Article requires the victim to be aware of the inhuman and degrading treatment which he/she is experiencing, the Article does not apply to PVS patients. This is because, they are not believed to be able to feel or appreciate what is happening (i.e., they are insensate or in a state of non-awareness).⁴² Thus the Human Rights Act 1998 was interpreted as being compatible with the principles established in *Bland*.

The *Bland* model was also not affected by the need to now assess best interests within the framework of the Mental Capacity Act 2005. This Act, which came into force in October 2007, now governs decisions relating to patients who lack capacity. As it was designed to promote autonomy, doctors are expected to firstly ascertain whether the patient has, while competent, made an advance decision that he/she would not want life-sustaining treatment and medical support to be carried out or continued should he/she find him/herself incompetent to make that decision in the future.⁴³ If an advance decision is present, doctors need to comply with the wishes of the person. It is important to note that although the Act provides for anticipatory decisions, this only refers to refusal of treatment. The patient or his/her family cannot therefore demand nor insist on the continuation of life-sustaining treatment through this mechanism.⁴⁴ This includes CANH since it is categorised as medical treatment.

If no advance decision has been made, the Act states that any decision made for or on behalf of a person who lacks capacity must be made in his best interests.⁴⁵ In deciding best interests, the 2005 Act expects several factors to be considered.⁴⁶ These include, so far as reasonably ascertainable, the patient's past wishes and feelings; beliefs and values that would be likely to influence his decision if he had capacity; and any other factors that he would be likely to consider if he were able to.⁴⁷ Account must also be taken of the views of others including those caring for him/her and those who are interested in his/her welfare.⁴⁸ The Act therefore incorporates a wider remit rather than just the clinical aspects of determining best interests.⁴⁹ It requires the informal statements made in the past which represented the once-autonomous patients' wishes, to be balanced against the contemporaneous welfare interests of the now incapacitated person. The two can, however, contradict one another.⁵⁰

A "best interests" decision is as objective a test as possible of what would be in the person's actual best interests, having taken all relevant factors into account.⁵¹ This can be contrasted to the "substituted judgement" test used in the USA.⁵² There, the decision-maker would determine what decision the patient would have him/herself made were he/she able to decide, as ascertained through a detailed inquiry into the patient's views and preferences (i.e., the hypothetical wishes of the incapable patient⁵³). The decision can then be made exclusively on the basis of what the now

⁴¹Anna Nowarska, *To Feed or Not to Feed? Clinical Aspects of Withholding and Withdrawing Food and Fluids at the End of Life*, 10 *Advances in Palliative Med.* 3, 4 (2011).

⁴²As Dame Butler-Sloss P. put it in *NHS Trust A v. Mrs M, NHS Trust B v. Mrs H*, "[a]n insensate patient suffering from persistent vegetative state has no feelings and no comprehension of the treatment accorded to him or her" – at paragraph 49.

⁴³Sections 24-26.

⁴⁴This is consistent with the scope of self-determination whilst alive, whereby one can refuse a proposed treatment however irrational the decision may seem to others, yet this does not extend to requests for treatment – see e.g., *St. George's Healthcare NHS Trust v. S*, 3 All ER 673 (1998); *Re T (adult: refusal of medical treatment)*, 4 All ER 649 (1992); and *Re B (adult: refusal of medical treatment)*, 2 All ER 449 (2002).

⁴⁵Mental Capacity Act 2005 Section 1(5).

⁴⁶*Id.* Section 4.

⁴⁷*Id.* Section 4(6)

⁴⁸*Id.* Section 4(7)

⁴⁹Alexandra Mullock, *Deciding the Fate of a Minimally Conscious Patient: an Unsatisfactory Balancing Act?*, 20(3) *Med. L. Rev.* 460 (2012).

⁵⁰Mary Donnelly, *Best Interests, Patient Participation and the Mental Capacity Act 2005*, 17(1) *Med. L. Rev.*, 1, 2 (2009).

⁵¹Julian Sheather, *Should We Respect Precedent Autonomy in Life-Sustaining Treatment Decisions?*, *J. Med. Ethics*, doi: 10.1136/medethics-2012-100663 (2012).

⁵²Note that the choice of using best interests, rather than substituted judgment, in the Act was a deliberate one - see Brenda Hale, *Mental Health Law* (London: Sweet and Maxwell, 2010), p. 66.

⁵³Marc Stauch, & Kay Wheat, *Text, Cases and Materials on Medical Law and Ethics* (Oxford: Routledge-Cavendish, 2011) p. 595; Emma Keane, *Withdrawal of Life-Support for Patients in PVS*, *Medico-Legal J. of Ireland* 83 (2011).

incapacitated person would have wished.⁵⁴ It is therefore a subjective test which is more respectful of the patient's precedent autonomy.⁵⁵ The best interests judgement, on the other hand, whilst now needing to incorporate past wishes hence giving some respect to the person's previous autonomy, balances this against more objective contemporaneous welfare or experiential interests.⁵⁶

In the case of PVS patients, the way this judgement has been used in the post-Mental Capacity Act 2005 era tends to place equal or more emphasis on the incapacitated individual's current welfare.⁵⁷ Once the diagnosis is confirmed and doctors have decided that the provision of any treatment is futile, even if the patient's prior wishes and values, or that of his/her relatives are for a different response (i.e., for continuation of life-sustaining treatment), these are neither determinative nor allowed by the courts to operate as a veto.⁵⁸

2. Case law

The manner in which the provisions of the 1998 and 2005 Acts were interpreted has not only endorsed, but fortified, the medico-legal framework established in *Bland*. It has also enabled this framework to incorporate other complexities associated with the care of PVS patients which the case itself did not have the opportunity to address.⁵⁹ It will be recalled that the case dealt specifically with the withdrawal of CANH and thereafter with the withholding of further interventions from a patient who was taken care of in a hospital setting. It also referred to the withdrawal of artificial ventilation even though this was not directly in issue as Anthony Bland was able to breathe unaided. Further, his family agreed unanimously with his doctors that all life-sustaining treatment should cease.

Subsequent cases have shown that courts have likewise been willing to declare lawful the withdrawal of CANH and other life-sustaining treatment from PVS patients taken care of in nursing homes⁶⁰ or specialist nursing homes.⁶¹ They have also been willing to make the declaration where there was disagreement among the PVS patients' family members.⁶² They have even done so in situations where the patients' entire family⁶³ or team of carers⁶⁴ were vehemently opposed to the doctors' proposal to stop all life-sustaining medical treatment.⁶⁵ In fact, courts were also prepared to authorise doctors not to replace gastrostomy tubes that had become accidentally dislodged from the patient's stomach⁶⁶ as well as those which had been obstructed and could not be unblocked.⁶⁷ Further, they have pronounced as lawful, attempts not to offer resuscitation to such patients in response to life-threatening events like breathing failure or cardiac arrest.⁶⁸ Controversially, courts have even entertained the possibility of dispensing altogether with the need to seek a declaration of lawfulness in cases of acute emergencies where a decision to cease life-sustaining treatment has to be made within a matter of minutes or hours.⁶⁹

Thus, whether the withdrawal of life-sustaining measures was a considered decision or one forced by events; whether the decision was supported or opposed by the patient's family or carers; whether the PVS patient was taken care of in a hospital setting or in a nursing home; whether the proposed

⁵⁴Mary Donnelly, *Determining Best Interests under the Mental Capacity Act 2005* 19(2) Med. L. Rev., 304 (2011).

⁵⁵Julian Sheather, *Withdrawing and Withholding Artificial Nutrition and Hydration from Patients in a Minimally Conscious State: Re M and its Repercussions*, J. Med. Ethics doi:10.1136/medethics-2012-100662 (2012).

⁵⁶*Id.*

⁵⁷*Id.*

⁵⁸Kenyon Mason & Graeme Laurie, *Mason & McCall Smith's Law and Medical Ethics* (Oxford: Oxford University Press, 2012) p. 509.

⁵⁹Owing to the need to stay close to the factual situation which was then before the court.

⁶⁰*A Primary Care Trust, An NHS Trust v. Mr CW (by his litigation friend the Official Solicitor), HW (Mother), PW (Father), AW (Brother), EW (Sister)*, EWHC 3448 (Fam) (2010).

⁶¹*The NHS Trust v. AW (by her litigation friend, the Official Solicitor)*, EWHC 78 (COP) (2013).

⁶²*Re G*, 3 Med. L. Rev. 80 (1995).

⁶³E.g., *An NHS Trust v. D*, EWHC 2439 (Fam) (2005).

⁶⁴*A Primary Care Trust, An NHS Trust v. Mr CW (by his litigation friend the Official Solicitor), HW (Mother), PW (Father), AW (Brother), EW (Sister)*, EWHC 3448 (Fam) (2010).

⁶⁵Note, however, that these objections were not made on religious grounds. Nor were they argued on the basis that the patients themselves would have wanted the medical interventions to continue were they able to communicate their wishes. The circumstances in the aforementioned 2012 Court of Protection case are therefore distinguishable and unprecedented.

⁶⁶*Frenchay Healthcare NHS Trust v. S*, 2 All ER 403 (1994).

⁶⁷*Swindon and Marlborough NHS Trust v. S*, 3 Med. L. Rev., 84 (1995).

⁶⁸*An NHS Trust v. D*, EWHC 2439 (Fam) (2005).

⁶⁹*Frenchay Healthcare NHS Trust v. S*, 2 All ER 403 per Bingham MR (1994).

withdrawal and withholding of life-sustaining measures relate to the patient's current situation or in anticipation of a life-threatening event in the future; declarations of lawfulness have been forthcoming. *Bland* and post-*Bland* cases have demonstrated that where doctors have confirmed the diagnosis of PVS, this automatically leads to the conclusion that CANH and other life-sustaining measures are "futile".⁷⁰ The courts have correspondingly never been hesitant to declare that it is indeed in the "best interests" of those patients to have those support removed or withheld. There is, in other words, only one set of response applied to the condition.

III. THE (BRITISH) MUSLIM COMMUNITY'S PERSPECTIVE ON PVS

The discussion thus far raises some very important questions for faith communities in Britain, whose ethico-religious frameworks impose a value system to be considered as part of the application or omission of technology. One such community is the Muslim community. Numbering approximately 2.7 million⁷¹ and consisting of diverse cultures and ethnicities,⁷² it is mainly located in the North West, Yorkshire, the Midlands and London.⁷³ Many within the community settled in the UK after the Second World War on the back of changes within immigration policies.⁷⁴ Its claims for public recognition has seen the Muslim UK resident allowed access to *halal* food, Muslim Schools, *sharia*-based finance packages, circumcision clinics and burial areas.⁷⁵ In addition, there are no legal restrictions placed on the observance of religious attire and duties in the workplace, nor on the construction or setting up of Mosques. UK charity law has also offered the same exemptions to religious buildings and organizations as for other faiths. Further, a seasonal Hajj consulate has been established for British pilgrims, making this a unique development in the western hemisphere.⁷⁶

The secular UK landscape has undoubtedly been embrave and accommodating of community needs within the fabric of British society. However, this has also attracted intra-community debate and a plethora of opinions on finer points regarding some of the issues highlighted in the preceding paragraph. Notwithstanding this,⁷⁷ it has made "living Islam" (i.e., living according to Islamic principles) in the UK a reality for the Muslim domicile. This is perhaps to an even larger degree than in some countries where the majority population is Muslim where such liberal accommodation of faith views is not witnessed. Although there may well be a range of both community and scholarly opinions on a variety of issues concerning the UK Muslim community, there is also a growing consensus of opinion on the more generic areas. This has facilitated adjustment to public policy to meet the needs of the Muslim community.

Given that healthcare in the UK has been significantly revolutionised after the Second World War, and how the British society itself has diversified and become very multi-faith during this period,⁷⁸ the

⁷⁰Kenyon Mason & Graeme Laurie, *supra* n. 58, at 510. The fact that it is highly related to the diagnosis is particularly clear when PVS is contrasted to MCS (minimally conscious state). In MCS, even where the patient's chance of recovery may be negligible (hence treatment would not bring about recovery, thereby equally "futile"), courts did not sanction the withdrawal of CANH – see *W v. M*, EWHC 2443 (Fam.) (2011). For discussion, see, Emily Jackson, *supra* n. 37; Carolyn Johnston, *The Weight Attributed to Patient Values in Determining Best Interests*, J. Med. Ethics, doi: 10.1136/medethics-2012-100916 (2012); Richard Huxtable, "In a Twilight World? Judging the Value of Life for the Minimally Conscious Patient", J. Med. Ethics, doi: 10.1136/medethics-2012-101028 (2012); Walter Glannon, *Burdens of ANH Outweigh Benefits in the Minimally Conscious State*, J. Med. Ethics, doi: 10.1136/medethics-2012-100882 (2013).

⁷¹Office for National Statistics, *Religion in England and Wales 2011*, available at http://www.ons.gov.uk/ons/dcp/171776_290510.pdf (last accessed 31 October 2013).

⁷²Leon Moosavi, *Why Has the Number of Muslims in the UK Risen So Much?*, available at http://www.huffingtonpost.co.uk/dr-leon-moosavi/why-has-the-number-of-mus_b_2279610.html?utm_hp_ref=tw (last accessed 31 October 2013).

⁷³Muhammad Anwar, *Muslims in Britain: Demographic and Socio-Economic Position*, in Aziz Sheikh and Abdul Rashid Gatrad (eds.), *Caring for Muslim Patients* (Oxford: Radcliffe Medical Press Ltd, 2000), 9.

⁷⁴*Id.*, 4; Shane Brighton, *British Muslims, Multiculturalism and UK Foreign Policy: "Integration" and "Cohesion" in and beyond the State* 83(1) Int'l Aff., 1, 12 (2007).

⁷⁵Yvonne Yazbeck Haddad & Tyler Golson, *Overhauling Islam: Representation, Construction, and Cooption of "Moderate Islam" in Western Europe*, 49 J. of Church and St. 487, 507–511 (2007); Tariq Modood & Stephen May, *Multiculturalism and Education in Britain: an Internally Contested Debate*, 35 Int'l J. of Educ. Res., 305, 310 (2001); Ihsan Yilmaz, *Muslim Law in Britain: Reflections in the Socio-Legal Sphere and Differential Legal Treatment*, 20(2) J. of Muslim Minority Aff., 353, 355 (2000).

⁷⁶*British Foreign Office launches special British Hajj delegation to Makkah*, available at <http://www.paktribune.com/news/print.php?id=161576> (last accessed 31 October 2013).

⁷⁷These differences in opinion are of course accepted within Islamic law provided the jurists have been compliant with the sources of Islamic law in their methodology and independent reasoning.

⁷⁸Abdul Rashid Gatrad & Aziz Sheikh, *Medical Ethics and Islam: Principles and Practice*, 84 Archives of Disease in Childhood 72 (2001).

discussion regarding the application of the conceptual medico-legal framework regarding medical futility and the Muslim patient seems a logical extension of this discourse on the accommodation of migrant communities within a secular but multi-faith Britain. This is so, irrespective of minor disagreements within communities and followers of different schools of thought. The issues mentioned earlier, enlisted as part of public recognition, focus on “loyalty to faith” whilst alive. Whereas, the medical futility debate focuses on loyalty to faith whilst dying. This precarious balance in life and death issues; between societal values and faith-based community values; or from an Islamic legal sense, text and context; is tentatively achieved in the areas identified above, making living Islam a possibility. This allows the Muslim domicile a profound sense of British identity and faith loyalty. The medical futility discourse, if sensitively addressed, can facilitate a similar redress. In tackling the issue, this part of the work firstly outlines the epistemology of Islamic law before exploring the management of PVS patients from an Islamic perspective.

A. The *Sharia* on end of life decision-making

In the UK, as in many other countries, governance (within institutions or regarding medical intervention) around death poses many an ethical impasse for both carers and the cared. For the Muslim, the Islamic thought framework plays a very important role on end of life healthcare decision-making just as it does during life. It is necessary to acquaint oneself with this framework in order to assess the experience of the Muslim patient and how to sensitively address any issues.

These issues within Islamic thought would be broadly located within the science of *fiqh* (jurisprudence) or human interpretations or extrapolations of God’s law (*Sharia*).⁷⁹ *Fiqh* scholars, in their efforts to understand God’s law, have classified human welfare into three distinct hierarchical categories: necessities, needs and embellishments.⁸⁰ Necessities would be primarily prioritised at a time of conflict, while embellishments would merit the least priority. The first category is founded on a set of preservatory principles:⁸¹ the preservation of religion, life, intellect, property, and genealogy/honour.⁸²

Fiqh governs an individual’s private and public life in all areas, ranging from: sincerity of intent, personal hygiene, ritual observance, family life, neighbourly conduct, promoting human welfare, commerce and mercantile life, hunting, marriage, divorce, inheritance, bequest, burial procedure, etc., as well as societal governance and public administration.⁸³ *Sharia* law also classifies actions into a broad (value) range of being mandatory, recommended, permissible, disliked, and forbidden.⁸⁴ This gives value to the present discussion of understanding medical futility as it gives hierarchical importance to seeking medical treatment in different situations.

The framework in academic terms could be referred to as the epistemology of Islamic thought and behaviour (also referred to as *usul al fiqh*). It, in essence, is how decisions are finalised and observances and practices are based upon (the legal methodology). This framework, based on the *Qur’an*, also guides behaviour and thought on end of life decision-making. It is based on primary and secondary sources. The primary sources are the *Qur’an* and the *Hadith* (Prophetic traditions). Both are seen as forms of revelation and as such, highly revered and respected. The secondary sources are the consensus of scholarly opinion and analogical deduction.⁸⁵ The secondary sources or at least recourse to them are activated upon the absence of guidance within the primary sources. But, even then, the decision must be based on an effective cause within the primary sources.

⁷⁹For an in-depth discussion, see Irshad Abdal-Haqq, *Islamic Law: An Overview of its Origin and Elements*, 1(1) J. of Islamic L., 1 (1996).

⁸⁰Saeed al-Harbi, *Fiqh al-muwazanah wa hayat al-Imam wa al-khatib lahu* at http://uqu.edu.sa/files2/tiny_mce/plugins/filemanager/files/4230042/feqh_almowaznah.pdf (last accessed 31 October 2013) & Yusuf Qaradawi, *Fiqh al-muwazanah* at <http://www.qaradawi.net/library/66/3269.html>, 4 (last accessed 31 October 2013).

⁸¹For an in-depth discussion on the preservatory principles see Muhammad Hashim Kamali, *Maqasid al-Shari’ah Made Simple*, Occasional Paper Series 13, The International Institute of Islamic Thought (2008); Jasser Auda, *Maqasid al-Shariah: A Beginner’s Guide*, Occasional Paper Series 14, The International Institute of Islamic Thought (2008); and Muhammad Umar Chapra, *The Islamic Vision of Development in Light of Maqasid al-Shariah* Occasional Paper Series 15, The International Institute of Islamic Thought (2008).

⁸²Shahid Athar, *Enhancement Technologies and the Person: an Islamic View*, 36 J. of L., Med. and Ethics 59, 61 (2008).

⁸³Abdullah Saeed, *Islamic Thought: An Introduction* (Abingdon: Routledge, 2006), 44–45.

⁸⁴Wael Hallaq, *A History of Islamic Legal Theories: An Introduction to Sunni Usul al-Fiqh* (Cambridge: Cambridge University Press, 1997), 40.

⁸⁵Andrew Rippin, *Muslims: Their Religious Beliefs and Practices* (Abingdon: Routledge, 2012), 92-93 and Patrick Glenn, *Legal Traditions of the World* (Oxford: Oxford University Press, 2000), 159–162.

Further, any discussion on the application or omission of technology at the end of life must consider a set of further concepts as part of the above framework: the concept of sanctity of human life within Islam, view on illness, concept of the human as a trustee of his/her body, view on seeking medical treatment and the definition of death and its determinants. The consideration of these values can greatly assist to determine the delineation between medical futility and medical expedience, at least from an Islamic perspective.

In *fiqh* terms, this debate is located within the discourse of termination of life by the cessation or withholding of medical care, or omission of life support systems. The preservatory principle concerned is the protection of life. For this, it is important to observe that Islam places a premium on the sanctity of life.⁸⁶ It is for this reason that suicide,⁸⁷ physician-assisted death and voluntary euthanasia are strictly forbidden in Islam.⁸⁸ It is believed that each person's longevity is only known by God and the exact timing of death is the sole prerogative of God.⁸⁹ Human beings, as embodied souls, are mere trustees rather than owners of their bodies. As such, they are placed under an obligation to take good care of this physical entity which has been entrusted to them. When the body is afflicted with an illness or an accident, it becomes incumbent upon the Muslim to seek treatment, and to persevere in this search for a cure.⁹⁰ In this endeavour, they are reminded by the *Hadith* that no disease is sent by God except He has sent a cure for it.⁹¹ This statement is taken literally and is seen as a clear encouragement to seek and research cures for illnesses. Hence, they should not give up hope on the grounds that no apparent improvement is discernible.⁹²

Thus, despite the fact that pain and suffering caused by illness are deemed as predestined,⁹³ by the permission of God,⁹⁴ a test of faith from God⁹⁵ and the forbearance of which could lead to the expiation of one's sins,⁹⁶ this does not discount in any way the need to make every effort to relieve one's suffering.⁹⁷ Arguably this, by extension, advocates the view that treatment is *never* futile in Islamic thought, until of course the patient is indisputably dead. Such a position would render problematic the whole concept of futility on which *Bland* rests.⁹⁸

The Quran also reminds Muslims in three places that each soul shall taste death⁹⁹ and it is the extraction of the soul by God which ultimately determines death.¹⁰⁰ Although the precise moment of when this happens is not made clear by the Quran, many Muslim scholars now accept brain stem death as the definition of death.¹⁰¹ Since brain stem dead patients are unable to breathe independently and would have no heartbeat without the assistance of medical technology, some Islamic legal experts allow for the mechanical ventilator and other life-sustaining measures to be discontinued on the grounds that the individual has died and the soul has departed.¹⁰² An analogous consideration into

⁸⁶Kamyar Hedayat & Roya Pirzadeh, *Issues in Islamic Biomedical Ethics: a Primer for the Pediatrician*, 108 *Pediatrics* 965 at 970 (2001).

⁸⁷Qur'an, Surah *Al-Baqarah* verse 195 and Surah *Al-Nisa* verse 29.

⁸⁸According to the Qur'an Surah *Al-Maidah* verse 32, "taking a single life is tantamount to killing all of mankind". See also Ajit Shah and Mahmood Chandia, *The Relationship between Suicide and Islam: a Cross-National Study*, 2(2) *J. of Inj. and Violence Res.* available at <http://jivresearch.org/jivr/index.php/jivr/article/view/60> (2010) (last accessed 31 October 2013).

⁸⁹Mohammad Zafir Al-Shahri & Abdullah Al-Khenaizan, *Palliative Care for Muslim Patients*, 3 *J. of Supportive Oncology* 432, 435.

⁹⁰*Id.*, 432.

⁹¹*Sahih Al-Bukhari*, The Book of Medicine, vol. 7, chapter 1, *hadith number* 582, p. 395 (in *The Translation of Meanings of Sahih Al-Bukhari* (Arabic-English) by Muhammad Muhsin Khan published by Dar al-Fikr, Beirut, n.d).

⁹²Abdul Rashid Gatrad & Aziz Sheikh, *Palliative Care for Muslims and Issues Before Death*, 8(11) *Int. J. Palliat Nurs.* 526, 528 (2002).

⁹³Qur'an Surah *Al-Hadid* verse 22.

⁹⁴Qur'an Surah *Al-Taghabun* verse 11.

⁹⁵Qur'an Surah *Al-Baqarah* verse 155 and Surah *Al-Ankabut* verse 1.

⁹⁶*Sahih Al-Bukhari*, The Book of Patients, vol. 7, chapter 1, *hadith number* 544, p. 371 (in *The Translation of Meanings of Sahih Al-Bukhari* (Arabic-English) by Muhammad Muhsin Khan published by Dar al-Fikr, Beirut, n.d).

⁹⁷Mohammad Zafir Shahri & Abdullah Al-Khenaizan, *supra* n. 89, at 432.

⁹⁸See the discussion in Part III.B below.

⁹⁹Qur'an Surah *Al-Imran* verse 185, Surah *Al-Anbiya* verse 35 and Surah *Al-Ankabut* verse 57.

¹⁰⁰Qur'an Surah *Al-Zumar* verse 42.

¹⁰¹See e.g., *UK's Muslim Law Council Approves Organ Transplants*, 22 *J. of Med. Ethics* 99 (1996); Declaration of the Academy of Islamic Jurisprudence; Faroque Khan, *Religious Teachings and Reflections on Advance Directive: Religious Values and Legal Dilemmas in Bioethics; an Islamic Perspective*, 30(1) *Fordham Urb. L.J.* 267 (2002); Abdullah Al-Khader, *The Iranian Transplant Programme: Comment from an Islamic Perspective*, 17 *Nephrol Dial Transplant* 213 (2002).

¹⁰²Kamyar Hedayat & Roya Pirzadeh, *supra* n. 86, at 969.

whether the souls of PVS patients have already been taken or not, has not emerged. But, can life-sustaining measures, including CANH, be similarly discontinued for Muslim PVS patients?

B. An exploration into the management of Muslim PVS patients

In exploring the management of PVS patients from an Islamic perspective, it is important to firstly highlight that CANH is generally considered as basic care.¹⁰³ This is because, nutrition and fluids are the essentials for maintaining life.¹⁰⁴ There are a number of variant scenarios as to whether these and other life-sustaining and life-saving measures could be withdrawn and withheld. The variants, presented in diagrammatic form, are as follows:

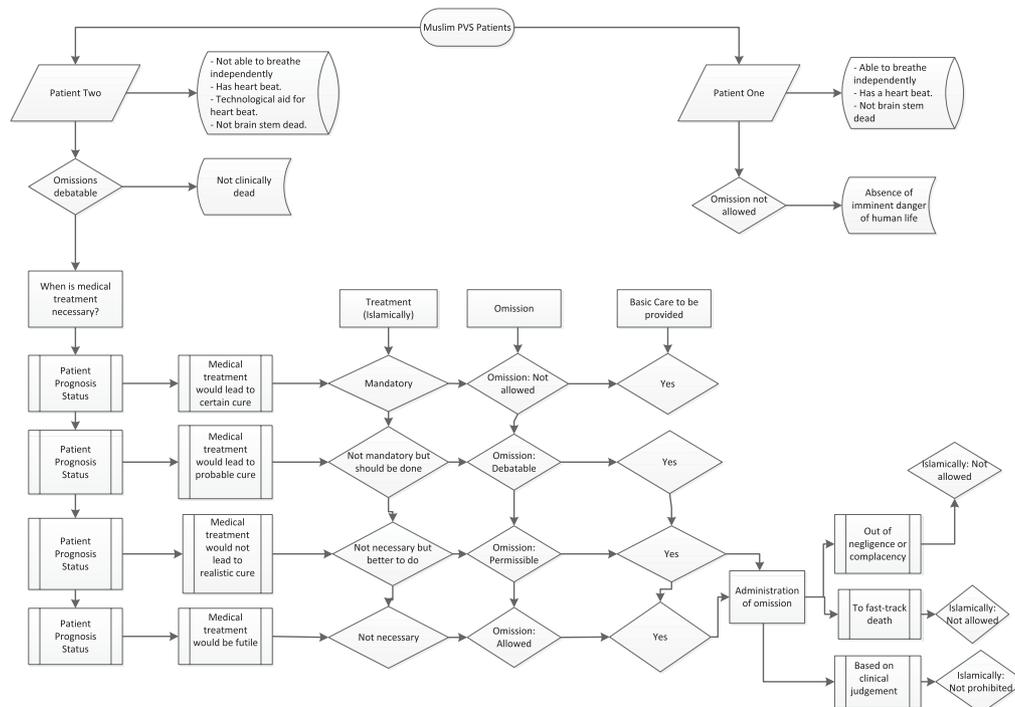


Figure 1. Management of Muslim PVS patients.

Referring to the above (Figure 1),

1. Where an individual (Patient One) is able to breathe independently and there is a normal heart beat without any technological aid (as in most PVS cases), omission would not be allowed given the absence of any imminent danger on human life.
2. Where an individual (Patient Two) is only able to breathe and has a heartbeat because he is supported by medical technology but he is not brain stem dead, omission is debatable in this scenario. The debate will revolve on the question: when is medical treatment necessary? The answer to this question is subject to further permutations.
 - 2.1. If the administration of food, fluids and any other life-sustaining and life-saving treatment would lead to cure (consciousness) and the lack thereof would lead to death, then the administration would be mandatory (i.e., otherwise a sin) and omission would not be allowed.
 - 2.2. If life-sustaining and life-saving medical treatment would lead to *probable*, rather than *certain* cure, then it *should* be undertaken but it is *not* mandatory (i.e., not otherwise sinful). Fluids and nutritional support (CANH) must nevertheless continue to be administered as these are basic care.¹⁰⁵

When deliberating on the situations in 2.1 and 2.2, it is important to remember that our earlier discussion in Part II implied that the medical profession is merely pessimistic,

¹⁰³Sami Al-Solamy, *Islamic Views on Artificial Nutrition and Hydration in Terminally Ill Patients*, Bioethics, doi: 10.1111/j.1467-8519.2012.01996.x (2012).

¹⁰⁴*Id.*

¹⁰⁵Faroque Khan, *supra* n. 101, at 271.

as opposed to convinced, that PVS patients can never recover consciousness. After all, as highlighted, there have been cases where patients regained consciousness after numerous years of being in this condition. Although the medical profession may have dismissed these as cases of wrong diagnoses or inexplicable “miracles”, these phenomena not only raise doubts on the hopelessness of any given situation, they also correspond to the Islamic worldview that treatment is never futile until the patient is definitely dead. As for the distinction drawn under Islamic law between situations where life-sustaining treatment “would lead to cure” (2.1) and “would lead to probable cure” (2.2), it is arguable that the former is more relevant for patients who have been in a vegetative state for 12 months or less, or not too many months or years after the first 12 months. The latter refers to those who have been in this condition substantially longer.

- 2.3. If life-sustaining and life-saving medical treatment would not lead to any realistic cure, then omission would be permissible¹⁰⁶ although attempting to cure would be better. As above, fluids and nutritional support must nevertheless continue to be administered until death occurs.¹⁰⁷
- 2.4. If the administration of food, fluids and life-sustaining and life-saving medical treatment is futile (i.e., beyond any reasonable doubt that it will not lead to recovery of consciousness)¹⁰⁸ based on robust medical evidence, then omission would not be disliked (i.e., allowed).¹⁰⁹

The situations described in 2.3 and 2.4, could be distinguished from those in 2.2 by reference to the severity of the patient’s condition. So, if for example the patient’s brain was liquefied at the moment when the case was deliberated on, thereby strongly indicative that restoration of consciousness is highly unlikely,¹¹⁰ this could be grounds for engaging 2.3 or 2.4, rather than 2.2.

It is necessary to note that there are also four other sub-permutations to consider in the event of the omission allowance mentioned in 2.4:

- 2.4.1. If the omission is attributable to complacency or even negligence rather than medical need, then it is *not allowed* as the human body is seen as a trust and its safeguarding is necessary.
- 2.4.2. If the omission is with the intent of fast-tracking death, then it is also *not allowed* as this would be tantamount to the de-sanctification and killing-off of a human life as well as a compromise of a Quranic principle and a preservatory principle of the *Sharia* namely the protection of life.¹¹¹
- 2.4.3. If the omission takes place in the absence of any hope of recovery and is based on robust medical evidence rather than to simply fast-track death, then it would not be seen as tantamount to murder.¹¹² Since medical cure is not definitive in such circumstances, omission will *not* be prohibited.¹¹³
- 2.4.4. However, medical assistance is always theoretically encouraged (but not necessarily mandatory) in every scenario. If patient autonomy is lacking within the decision-making process (i.e., medical opinion outweighs the wishes of the patient or his/her family) and the technology sustaining life is withdrawn, then the patient would not be held responsible. This is based on the Islamic viewpoint discussed above that for every illness there is a cure except death. Thus, the pursuit of a cure will always be laudable.

¹⁰⁶Michael Schultz *et al.*, *Reflections on Palliative Care from the Jewish and Islamic Tradition*, Evidence-Based Complementary and Alternative Med. 1, 4 (2012).

¹⁰⁷Faroque Khan, *supra* n. 101, at 271.

¹⁰⁸For a detailed understanding of “reasonable doubt” and “robust medical evidence”, see Royal College of Physicians, *supra* n. 11.

¹⁰⁹Mohammad Zafir Al-Shahri & Abdullah Al-Khenaizan, *supra* n. 89 at 433.

¹¹⁰Peter McCullagh, *Conscious in a Vegetative State? A Critique of the PVS Concept* (Dordrecht: Kluwer Academic Publishers, 2004) 109.

¹¹¹Islamic Medical Association of North America (IMANA), ‘Islamic Medical Ethics: The IMANA Perspective’, paragraph 4(D).

¹¹²Abdul Rashid Gatrad, *Muslim Customs Surrounding Death, Bereavement, Post-Mortem Examinations, and Organ Transplants*, 309 Brit. Med. J., 521 (1994).

¹¹³Hamdan Al-Jahdali, *et al.*, *Advance Medical Directives: a Proposed New Approach and Terminology from an Islamic Perspective*, 16(2) Med., Health Care and Phil., 163, 166 (2013).

Consequently, technology, no matter how advanced and progressive, cannot be without boundaries. The religious and cultural dimensions need to be considered at all times as part of patient-care.¹¹⁴

However, where there is competition for the same resources by another patient with a better medical prognosis, there would be grounds to consider omission. This conflict of resource allocation can be viewed as a tension between two principles: preservation of life and preservation of property. It can be addressed through the concept of *fiqh al-muwazana* or comparative jurisprudence or even the jurisprudence of disagreement or theory of conflict.¹¹⁵ This is a logical thought process which adheres to the hierarchy of *fiqh* of looking after necessities, then needs, and then embellishments. At times of conflict, this tool could help in the decision-making process to resolve the question of whether the seemingly futile treatment can be terminated in order to use the finite resources for the benefit of another human life or to preserve a public resource. The application of this tool would require consideration of the following: the text (scripture) and the context (i.e., what is the greater good, which is the lesser of two evils, repelling evil is better than acquiring good, what is most beneficial for mankind, and what is the welfare and detriment for the human).¹¹⁶ Once the aim of *Sharia* becomes apparent, it should be rigorously pursued.

Thus unlike the standardized position taken in secular law, Islam does not apply a generic approach in the management of PVS patients. Rather, the merits of each case should be individually considered. Muslim jurists have recommended that decisions in such critical cases, i.e., where there is information provided by humans (in this instance doctors) which has a direct coercive effect upon another human (in this instance a PVS patient), must not be taken by just an individual person. Rather, it should be taken collectively by a team of not only appropriately qualified and competent physicians, but equally trustworthy ones with impeccable character.¹¹⁷ This ensures that the integrity of the decision making process can be maintained since it would help eliminate errors in judgment and biasness.¹¹⁸ Although the doctors in question do not necessarily have to be Muslims, Islamic law would see this opinion as tantamount to giving a testimony on a matter.

IV. RECOMMENDATIONS AND CONCLUSION

From the time of *Bland*, the first PVS case presented before the English courts, judges have consistently countenanced the withdrawal of life-sustaining treatment and subsequent withholding of medical support from patients with a PVS diagnosis. As discussed, this tendency on the part of English law to use the same set of response for all PVS patients can be inconsistent with the religious values of the Muslim community. For practising and devout Muslims, living as a Muslim is equally important to dying as a Muslim. Islam is a comprehensive way of life which also informs their motivations and decisions regarding medical issues.¹¹⁹ Hence they are not at liberty to compromise religious standpoints and prescriptions on seeking medical care, nor lessen their abiding faith in God's omnipotence¹²⁰ should they one day be, or find their family members, in a persistent vegetative state.¹²¹ The narrative within this article has therefore argued that religious values should be allowed to illuminate thinking around end of life medical care.

Here, it is instructive to note that adjustments based on religious grounds have already been successfully attained in some jurisdictions for a highly controversial issue such as the definition of death. The laws in Japan¹²² and Israel¹²³ for example, currently allow death to be determined either on the basis of neurological or cardiac-respiratory criteria. Such legal recognition of a dual definition of death was made for the benefit of faith communities that object to a brain-based method of

¹¹⁴Vardit Rispler-Chaim, *Islamic Medical Ethics in the 20th Century*, 15 J. Med. Ethics 203 (1989).

¹¹⁵For a detailed discussion on *fiqh al-muwazana*, see Saeed al-Harbi, *supra* n. 80.

¹¹⁶Simon Archer & Rifat Abdel Karim (eds.), *Islamic Finance: The New Regulatory Challenge* (Singapore: John Wiley & Sons, 2013) Chapter 11.

¹¹⁷Shaikh Mullah Jeevan Ahmad Ibn Abi Saeed, *Nur al Anwar* (Pakistan: Maktabah Rashidiyyah, 1967), 187–188.

¹¹⁸*Id.*

¹¹⁹Lance Laird, *et al.*, *Muslim Patients and Health Disparities in the UK and the US*, 92 Archives of Disease in Childhood 922, 923-924 (2007); Aasim Padela, *et al.*, *The Perceived Role of Islam in Immigrant Muslim Medical Practice Within the USA: an Exploratory Qualitative Study*, 34 J. Med. Ethics 365 (2008).

¹²⁰Santi Rozario, *Allah is the Scientist of the Scientists: Modern Medicine and Religious Healing among British Bangladeshis*, Asia Research Institute Working Paper Series No. 101 (2008) 3.

¹²¹John Oldershaw, *et al.*, *Persistent Vegetative State: Medical, Ethical, Religious, Economic and Legal Perspectives*, 1 DePaul J. of Health Care L. 495 at 511 (1996–1997).

¹²²Japanese Organ Transplantation Law of 1997.

¹²³The Brain-Death-Respiratory Law of 2008.

determining death.¹²⁴ Similarly, in the United States where whole brain death is accepted as the legal standard of death nationwide, laws have been passed in New Jersey¹²⁵ and New York¹²⁶ which allow faith communities to opt out of this brain-centred standard and be determined dead using a cardiac-centred definition instead. In the UK itself, doctors are now expected to comply with Jehovah Witnesses' refusal to have blood transfusion even if this would result in those patients' death.¹²⁷ To the extent that these demonstrate that religiously-sensitive care can be successfully implemented within secular legal frameworks, the religious voice on PVS matters too could be integrated within secular thought rather than be alienated from courtroom debates.¹²⁸ Indeed, the idea and attraction of a single law and legal interpretation for all is only appropriate for a society where everyone within shares the same religion and culture.¹²⁹

On the management of Muslim PVS patients, one needs to consider how two legal systems (secular law and Islamic law) with both common and distinct underlying values can come to a common ground. The examples cited at the beginning of Part III which allude to areas where this has been achieved (e.g., Islamic banking and Muslim schools), can provide a valuable context. If public policy has, in those areas, been adjusted to meet the religious needs of the British Muslim community, expanding this to the realm of health would simply represent a continuation of a trend of responding sympathetically to the needs of diverse communities and consolidating community cohesion.

As previously mentioned, all decisions for patients who lack capacity like PVS patients must now be made in line with the best interests test outlined in the Mental Capacity Act 2005 and that court approval is mandatory before life-sustaining measures are withdrawn and withheld. We respectfully suggest that when faced with applications from doctors for declarations of lawfulness, judges should be willing to adopt more than one way of interpreting "best interests". After all, as highlighted previously,¹³⁰ section 4 of the Mental Capacity Act 2005 states that where the determination of best interests relates to life-sustaining treatment, so far as is reasonably ascertainable, attention must be paid to the past wishes, feelings, beliefs and values of the patient, and the views of his/her family and others engaged in his care or interested in his welfare. Where the PVS patient is a Muslim (or from another faith tradition that also objects, on religious grounds, to the cessation of medical intervention purely because a diagnosis of PVS was made),¹³¹ judges should attempt to interpret what is in the patient's best interests in light of religious sensitivities in much the same way as they have done for Jehovah's Witnesses. Doctors (either those treating the patient and/or others who have extensive experience of caring for PVS patients) and religious leaders could be asked for their views on where each of those patients would sit in the situations mapped out in Figure 1 above. This way, the current standardised response to the legal management of PVS patients could be reasonably adjusted to enable the care of Muslim PVS patients to be continued in certain conditions.

In advocating this, it is necessary to address the crucial question of how to convince doctors to continue to treat such patients when prolongation of care is judged by them as medically inappropriate. In other words, how does one ensure that they do not spontaneously seek a declaration from the court to terminate the treatment? Or if they have done so and the court refuses to make a declaration, on account of the interpretation mentioned in the preceding paragraph, that they equally honour professional integrity to patient care. This in effect underlines the need for more heightened awareness and appreciation among healthcare professionals about Islamic teachings. Those with very little specific knowledge of Muslim religious life may find it difficult to conceptualise spirituality, as understood, outside the Western religious and secular norms.¹³² Not only would training on this

¹²⁴For further discussion, see Kartina A. Choong, *Organ Procurement: a Case for Pluralism on the Definition of Death*, 1(1) J. of Med. L. and Ethics 5 (2013).

¹²⁵New Jersey Declaration of Death Act 1991, Title 26.

¹²⁶New Codes Rules and Regulations (1987), Title 10, s.400-16.

¹²⁷*Re T (Adult: Refusal of Medical Treatment)*, 4 All ER 649 (1992).

¹²⁸Audil Rashid, *Muslim Families: Donating Organs and Asking for Post Mortems*, 85 *Archives of Disease in Childhood* 79 (2001).

¹²⁹Rajnaara Akhtar, *British Muslims and the Evolution of the Practice of Islamic Law with Particular Reference to Dispute Resolution*, 6 J. of Islamic St. Prac. Int'l 27, 38 (2010).

¹³⁰See the discussion in Part II.B.1.

¹³¹E.g., those from the Jewish faith tradition – see Meir Katz, *When is Medical Care "Futile"? The Institutional Competence of the Medical Profession Regarding the Provision of Life-Sustaining Medical Care*, 90 Neb. L. Rev. 1, 1–4 (2011).

¹³²Lance Laird, *et al.*, *supra* n. 119, at 925.

matter promote sensitive and empathetic caring for their Muslim patients,¹³³ it could also prevent religiously-based objections to cessation of life-sustaining treatment from leading to antagonism and confrontation.¹³⁴

Last but not least, since healthcare in the UK is delivered through a publicly funded National Health Service (NHS), there may undoubtedly be a need to consider the issue of the potential disproportionate use of resources by a particular community, and the moral and legal issues this may give rise to.¹³⁵ To develop an informed understanding of the challenges involved in achieving a balance (between scarce NHS resources and the needs of particular communities for religious observance in circumstances where continuation of care seems to be religiously obligatory or approved), extensive debate is called for among medical, legal and religious representatives. This article hopes that it has managed to draw appropriate attention to the urgent need for this to take place.

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¹³³Mohammad Zafir Al-Shahri & Abdullah Al-Khenaizan, *supra* n. 89, at 435; Michael Schultz, *et al.*, *supra* n. 106 at 6; David Mitchell, *Spiritual and Cultural Issues at the End of Life*, 36(2) *Med.* 109, 110 (2007).

¹³⁴Michael Schultz, *et al.*, *id.*, at 2.

¹³⁵Charles Foster, *The Metaphysics of Feeding-Tubes: The Law and Ethics of Withdrawing Life-Sustaining Treatment*, 154 *Christian L. Rev.* 57, 61 (2005); Charles Foster, *Dementia, Best Interests and Budgets*, 155 *New L.J.* 144 (2005).