Review of the Legal Maxims of Islamic Law on Palliative Sedation: Concerns of the Arabic Bioethicists

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ABSTRACT

The complexity of symptoms of terminally ill patients can present an unendurable experience at the end of life. One contested issue sits at the forefront of end of life care, which is the palliative sedation.

Palliative sedation is a medical practice that is acknowledged and used as a last resort or controlling refractory symptoms. It has received considerable global attention lately, but has not been adequately addressed in Islamic literatures within the Arab world. The tension around palliative sedation is grounded in competing concerns. The first concern, alleviation of the suffering of a human being, is considered very righteous. The second concern, maintaining a level of consciousness as close to normal as possible, is of great importance to allow for the observance of the worship rites for the longest period possible before death. The third concern is the absence of Islamic rules that particularly legalize or prohibit palliative sedation.

This study, therefore, attempts to examine the legal status of this practice and explore the Islamic rules and ethical boundaries that might govern it. In-depth qualitative studies to affirm and expound any ambiguity in the definition and the practice of palliative sedation are urgently needed.

Keywords:
- Terminal illness
- Palliative sedation
- Decision making
- Islamic law
- Saudi Arabia

INTRODUCTION

The complexity of symptoms of terminally ill patients can present an unendurable experience at the end of life. Although some of these symptoms are effectively controlled, others become refractory and uncontrollable with the conventional treatment. Refractory symptoms, apart from having a negative impact on the patient’s quality of life and well-being, often increase as the patient approaches the end of life and interfere with a peaceful dying process [1]. When a patient with incurable disease progresses to the terminal phase, body processes such as urine output, intestinal motility, and heart rate slow down, breathing becomes shallow and ragged, and the patient is said to be actively dying. When someone is actively dying, death is expected in hours to days or perhaps within a week or two [2].

The organization and delivery of end-of-life care in each country relies on a variety of clinical, ethical, and socio-cultural assumptions that fundamentally influence the nature of the experiences of care and dying for the very ill people and their professional and family caregivers [3]. In all cases, clinical action at the end of life involves a number of complex factors: determining and then trying to act according to the best interests or wishes of a dying person; giving comfort to them and their care-givers; attempting to enhance their self-determination where possible; balancing any known patient or family wishes with the potential for medical benefit; and following legal and ethical codes governing end-of-life care [4].

One contested issue sits at the forefront of these concerns, and that is “palliative sedation,” - a last resort for controlling the refractory symptoms. Palliative sedation at the end of life is a medical practice that is commonly acknowledged and used and has received considerable attention lately. Terminal sedation was considered controversial from the beginning of palliative care, with critics claiming that it was “slow euthanasia” or mercy killing in disguise [5].

From an Islamic perspective, no published studies have addressed the practice of palliative sedation in Islamic countries or have examined the debates inherent to palliative sedation. Therefore, it is important to examine the legal status of this practice and explore the Islamic rules that might govern it. The goal of this paper is to use and evaluate the relevant ethical boundaries inherent in palliative sedation, specifically in the Islamic context.

HISTORY AND COMPETING DEFINITIONS

Palliative Sedation and Terminal Sedation vs. Euthanasia

Dr. Robert Enck is often cited for coining the term “terminal sedation.” Although he did not specifically define terminal sedation, but he did present studies showing that some patients dying with cancer have unrelieved suffering in their final days, and that relieving this suffering could be accomplished only by reducing their consciousness alongside the necessary medications [2]. The adjective “terminal” was not simply an indicator of time, reflecting the final phase of a patient’s life when such sedation was typically administered; instead, it has been viewed as revealing the true purpose of the intervention, that is, to terminate the patient’s life [5]. The overlapping conception of this term with euthanasia has become controversial and led to the proposal of many new terms to replace it. “Palliative sedation” was first introduced in a paper by Materstvedt et al (2000) [6], and subsequently, the use of the terms “palliative sedation” and “palliative sedation therapy” increased. Other phrases that have been used in place of terminal sedation include “sedation for intractable distress in the dying” and “end-of-life sedation” [6].

Recommendations, guidelines, and standards for the appropriate implementation of palliative sedation have been issued by national and international organizations, all emphasizing the ethical differences between palliative sedation and euthanasia. De Graeff and Dean [6] have defined various levels of palliative sedation to aid the understanding of this concept: mild, intermediate, and deep. Mild and moderate sedation are considered standard practices, such as conscious sedation, and do not always reduce suffering to a level that is acceptable to the patient. The crucial contention
starts with “deep continuous sedation” (CDS) until death, with implications that it is a modern method of euthanasia or physician-assisted suicide, especially when combined with withholding artificial nutrition and hydration.

At the definition level, palliative sedation as a term resolved the ambiguity between euthanasia and terminal sedation because the latter terms have “collateral damage perception” in terminating patient life. Nevertheless, many published definitions for palliative sedation have almost the same step-wise structure. It is a procedure intended to relieve suffering from refractory symptoms, by lowering the level of consciousness, by using sedative medications, with terminally ill patients, and as a last option. In euthanasia, the intentional action is to terminate patient life to relieve suffering with the death taking place in minutes. The practice of euthanasia is measured both subjectively and objectively, and usually documented through protocols while having been previously secured with informed consent; the intention of the patient and the doctor is to end the life with death, and that is when the procedure has successfully achieved its aim. In the Netherlands, CDS until death is increasingly being used as a relevant alternative to euthanasia for elective requests for death [7].

Islamic Perspective

It is worthwhile to distinguish between palliative sedation, specifically CDS, and euthanasia and determine the Islamic stance on both. Islam upholds the sanctity of life, and a number of Qur’anic verses testify to this. Some are as follows: “And do not take any human being’s life - the (life) which Allah has willed to be sacred - other than in the (pursuit of) justice” [8]. Therefore, euthanasia as a procedure is forbidden in Islam, corresponding to the Holy Book, “the main source of binding regulations for all Muslims.” Any physician who prescribes, assists in, or carries out a euthanasia procedure at the command of the patient or the patient’s relatives or out of self-interest might be legally charged for criminal liability.

Islamic scholars and Islamic laws do not go beyond the distinction between active and passive euthanasia and forbid and criminalize the practice of euthanasia to end patient suffering. The Permanent Committee of “The General Presidency of Scholarly Research and Ifta” in Saudi Arabia issued a fatwa (decision) stating that: It is haram (prohibited) for a patient to hasten their death [9], whether by committing suicide or by taking medication to kill themselves; it is also haram for a doctor, a nurse, or any other person to carry out the patient’s request, even if their disease is incurable. Anyone who assists in this, shares in the sin because they intentionally kill a human, whose life is protected by Shari’ah’ (Islamic law). There are clear Nas (Islamic texts from the Quran or the Sunnah) prohibiting the killing of a human being without a right. Allah (exalted be He) says: “And kill not anyone whom Allah has forbidden, except for a just cause (according to Islamic law).”

CONTINUOUS DEEP SEDATION

Palliative care aims to relieve suffering and help patients and families with life-shortening illnesses live as actively as possible with good quality of life, neither hastening nor postponing death [10]. At times, some symptoms at the end of life become refractory to accessible and conventional treatment, even with mild or moderate palliative sedation. A last resort in such instances could be CDS, in which the patient is sedated until death. The tension around CDS at the end of life from the Islamic perspective is grounded in competing concerns. The first concern, alleviation of the suffering of a human being, is considered very righteous. The second concern, maintaining a level of consciousness as close to normal as possible, is of great importance to allow for the observance of the worship rites for the longest period possible before death [11]. The third concern is the absence of Islamic rules that particularly legalize or prohibit palliative sedation. Thus, with CDS, it is challenging to weigh these concerns and decide which one outweighs the other.

Philosophy of Legal Maxims of Islamic Law and Possible Interpretation of CDS

Islam is defined by orthopraxy rather than by orthodoxy. That is, it is more a religion of practice and law than a religion of doctrine, and the methodology of Islamic jurisprudence refers
mainly to rules of interpretation and deduction and methods of reasoning [12]. Legal doctrines and rules in addition to analogical reasoning based on theoretical cases enable Muslim jurists to expound and resolve ethical dilemmas about issues such as autopsy, organ donation, and the dignity of the dead [13]. Al-Qawa’id al-Fiqhiyyah (Legal Maxims of Islamic Jurisprudence) are theoretical abstractions, usually in the form of short statements, that are expressive, often in a few words, of the goals and objectives of the Shar`iah. The actual wordings of the maxims are occasionally taken from the Qura’n or Hadith but are more often the work of leading jurists [14].

CDS and the Purpose of Islamic Law (Maqasid Al Shariah)

The five Islamic purposes are preservation of religion, life, progeny, intellect, and wealth. Any medical action must fulfill one of the above purposes if it is to be considered ethical [15]. Two of these purposes are central in the discussion of CDS:

a) Preservation of Religion

We can argue in this purpose two premises that should be raised and examined. The first premise is protecting the religion from an act that carries the risk of future abuse by unscrupulous or inexperienced physicians when such acts might infringe this purpose by assuming Allah’s (God) prerogative of causing death. The predictability of success of the abuse might be affected by a failure to have robust policies or by the erosion of the moral system in health care settings. Opponents of palliative sedation may justify their position based on the principle of injury, when the distant harm and injury are foreseen; we follow the principle that the prevention of harm has priority over the pursuit of a benefit of equal worth [15]. Meanwhile, proponents of palliative sedation may invest the principle of hardship: “Necessity legalizes the prohibited.” Medical interventions that would otherwise be prohibited actions are permitted under the principle of hardship if there is a necessity [15]. In this situation, the ethical and philosophical question is whether relieving suffering at the end of life constitutes a necessity to override the principle of injury that constitutes death. However, the ultimate decision should be driven at the highest judicial and jurisprudence level.

The second premise is that it is of great importance for Muslims to allow for the observance of the worship rites for the longest period possible before death [11]. Opponents of CDS might argue that CDS would deprive the worshipper of a very critical practice before departing to the hereafter and deprive the family of their loved one and from promoting the practice of Islamic rituals before death. Most palliative patients as they approach the end of their lives, however, are powerless or incompetent to practice worship rites because of the burden of symptoms and altered cognition, recognized as a common problem at the end of life and associated with a worse prognosis [16]. Finally, the existence of suffering is a very stressful experience in terminally ill patients, making exploration of the ethical course and religious implication of CDS an imperative.

b) Preservation of Life

Unlike euthanasia, CDS is not an intentionally prearranged death, and the grey zone demarcating the intention in CDS still challenges the principle of sanctity of life. Measuring intention objectively is not feasible, and nobody is deemed able to envision the intention of any act. However, the aim of palliative care is not preventive or curative nor to hasten or postpone death. Opponents of CDS consider that the risk of hastening death in CDS is questionable and may jeopardize the sanctity of life. This course of argument is justified by the principle of intention (Niyya), in which each action is judged by the intention behind it [15].

Does CDS Hasten Death?

The pre-eminent purpose of using narcotic medication in palliative care is to control and relieve pain. The illicit use of opioids and other drugs that affect sensorium is strictly prohibited in Islam [11]. It is usually reasonably argued that CDS shortens life by hastening death. The presence of this kind of evidence-based data produces ethical dilemmas among opponents and proponents regarding whether or not to support the practice of CDS. Although some data show that CDS does not hasten the death of patients overall, a small risk of hastened death
for individual patients exists (through respiratory depression, aspiration, or hemodynamic compromise) [17]. Nonetheless, others are of the opinion that CDS has no life-shortening effect or at least no such effect has been proven. These authors refer to the clinical studies showing no difference in the length of survival between sedated and non-sedated patients [18]. Scarpi et al [16] have also concluded that “even if there is no direct evidence from randomized clinical trials, palliative sedation, when appropriately indicated and correctly used to relieve unbearable suffering, does not seem to have any detrimental effect on survival of patients with terminal cancer.” The presence of such evidence-based data produces more ethical quandaries.

The medical interventions that would otherwise be prohibited actions are allowed under the principle of hardship if there is a necessity [15]. Accordingly, the foreseeable undesired side effect “respiratory depression, drowsiness” might be justified because the necessity legalizes the prohibited. A dominant question arises: whether the use of sedative medication with patients suffering from pain and refractory symptoms, at the end of life or with actively dying patients, is justified and fits the criteria of the principle of hardship “the necessity legalizes the prohibited,” as it is in the case of using narcotics. A necessity (of the hardship principle) is defined in law as what threatens any of the five purposes of the law, namely religion, life, intellect, progeny, and wealth [15]. Moreover, according to the principle of certainty, all medical procedures are considered permissible unless there is evidence to prove their prohibition [15]. In this place, the strength of the evidence that CDS hastens death must be scientifically valid to decline the use of CDS. However, the answer for the abovementioned question is lawfully and exclusively confined to the Islamic jurists, and to exert a unified influence, it should be at the level of the institution.

One more point that is debated around the question of hastening death with CDS is withholding and withdrawing artificial nutrition and hydration, as it is considered passive euthanasia. First of all, the decision to start CDS does not necessarily imply withholding artificial nutrition and hydration. Also, artificial nutrition and hydration may be futile and diminish quality of life. It can harm the terminally ill patient because of complications such as aspiration pneumonia, dyspnea, nausea, diarrhea, and hypervolemia. From the Islamic perspective, withholding and withdrawing artificial nutrition and hydration can be explored according to the principle of injury: Injury should be prevented or mitigated as much as is possible [15]. Consequently, artificial nutrition and hydration can be withdrawn in case of anticipated harm because at this point, it will not provide a positive effect and more likely will be more burdensome. It is important to understand that in the imminently dying patient, the provision of artificial nutrition and hydration should be assessed regarding whether or not it will preserve the purposes of Islamic law (Maqasid Al-shariah) and should be balanced with the principles of Islamic law (Qawaid Al Shari’ah). This assessment and evaluation can be achieved only by authoritative jurists, with scientific input from palliative specialists and bioethicists.

CONCLUSIONS

At the conceptual level, the main and prevailing intention of CDS is to relieve suffering from refractory pain and other unendurable symptoms. However, being acquainted with patient preferences and values can aid in helping patients decide how to face their death. To summarize, absence of scientific studies within the Islamic context and a lack of examination of practice norms and the normative view of CDS from the Islamic perspective have rendered the definition of CDS more difficult in the field of palliative ethics. Addressing ethical dilemmas and religious and cultural boundaries requires collaboration between palliative care specialists, bioethicists, clinical pharmacists, and institutional jurists to affirm and expound any ambiguity in the definition and the practice of continuous deep sedation.

CONFLICT OF INTEREST

Authors have declared that no competing interests exist.
REFERENCES