



Pulling the Plug: The Islamic Perspectives on End-of-Life Care

MARYAM SULTAN

YAQREEN™
Institute for Islamic Research

Author Biography

Maryam Sultan is a resident physician in Houston, TX. She earned Bachelor's degrees in Biology and Middle Eastern & Islamic Studies from New York University. She went on to pursue a medical degree at Mount Sinai School of Medicine, and is now in the midst of residency training in the field of Physical Medicine and Rehabilitation, with focuses in musculoskeletal injuries and neurorehabilitation. She has pursued traditional Islamic learning since college through AlMaghrib Institute, Mishkah University, and the Foundation for Knowledge and Development.

***Disclaimer:** The views, opinions, findings, and conclusions expressed in these papers and articles are strictly those of the authors. Furthermore, Yaqeen does not endorse any of the personal views of the authors on any platform. Our team is diverse on all fronts, allowing for constant, enriching dialogue that helps us produce high-quality research.*

Copyright © 2017. Yaqeen Institute for Islamic Research

Abstract

Cultural competency and patient-centered care is best achieved when a physician has some understanding of a patient's beliefs and practices. The paucity of English-language literature on Islam's perspective on end-of-life care and life-sustaining measures in terminal illness makes caring for dying Muslim patients in the United States of America difficult. Decisions made by scholars of Islamic legislative assemblies, in consultation with medical professionals, are used for treating disease and employing life-sustaining measures in terminally ill patients. These rulings are based largely on an Islamic legal maxim that obligates the avoidance of harm. The following discussion will present information to enhance the experience of the Muslim patient receiving treatment and the healthcare professionals providing care by facilitating an understanding of Islam's teachings on medical treatment and end-of-life care.

Background

Cultural Competency

The issue of cultural competency, now an integral part of the Accreditation Council for Graduate Medical Education (ACGME) accreditation of medical schools and training programs, is a topic of growing importance in medicine. In fact, the ACGME has published *Roadmap for Hospitals*, which contains chapters on Treatment and End-of-Life Care. The importance of accommodating a patient's cultural, religious, or spiritual beliefs and practices is discussed as a critically important skill for physicians to obtain during training.¹ It is especially on the topic of death and dying that an ability to facilitate communication with patients and

¹ The Joint Commission. *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*. Oakbrook Terrace, IL: The Joint Commission, 2010. <http://www.jointcommission.org/assets/1/6/roadmapforhospitalsfinalversion727.pdf>

family members, as well as an understanding of their perspectives, is integral in the delivery of high-quality, patient-centered care. In discussing goals of care, physicians' understanding of patients' and families' values is essential for the delivery of culturally-appropriate guidance.

Little literature exists in the English language on the Islamic perspective on medical treatment and end-of-life care. With the growing population of Muslims in the United States, the relevance of these topics in medical practice has naturally increased. As a religion that permeates nearly every aspect of its followers' lives, Islam's perspective on various medical issues is useful knowledge for the physician in his/her quest to deliver patient-centered care and recommendations.

Life, Death, and Illness in an Islamic Spiritual Framework

Patients' spirituality typically correlates positively with coping during serious illness. A 2017 study showed that spiritual well-being and a sense of "meaning in life" were associated with lower self-reported levels of depression and anxiety and higher self-perceived levels of function among palliative patients at the end of life.² The purpose of life from an Islamic standpoint is made clear within the Qur'anic verse that declares, "And We did not create the jinn and mankind except to worship [God],"³ indicating that the goal of a human life is the worship of God alone. Death is considered a cessation of the life of the current world and a transition to the afterlife. The life of the grave is noted as a state of transition until Judgment Day, on which humans are recompensed for their worldly deeds. Illness, viewed from a spiritual perspective, is an opportunity to gain closeness to God and divine reward for patiently enduring hardship. However, as will be noted below,

² Bernard M, Strasser F, Gamondi C, Braunschweig G, Forster M, Kaspers-Elekes K, Veri SW, Borasio GD, the SMILE consortium team, Relationship between spirituality, meaning in life, psychological distress, wish for hastened death, and their influence on quality of life in palliative care patients. *Journal of Pain and Symptom Management* (2017), doi: 10.1016/j.jpainsymman.2017.07.019.

³ *The Quran*. Oxford World's Classics Ed. New York, NY: Oxford University Press; 2004: 51:56.

<http://islam24hours.yolasite.com/resources/Quran-Abdel-Haleem-Translation.pdf>. Accessed: November 22, 2013.

seeking treatment for illness is praiseworthy within an Islamic mindset and it is encouraged to combat morbidity and mortality.

Islamic Law and Medicine

Sources of Islamic Law & Types of Derived Rulings

Medical decisions based on Islamic law are derived from two types of sources: those on which there is unanimous agreement amongst scholars regarding their use in the derivation of law and those about which there is general agreement by the majority. Both types of sources are used in decisions regarding end-of-life care.

The sources on which there is unanimous agreement are the *Qur'an*, defined as God's word revealed to the Prophet Muhammad ﷺ in Arabic over the course of his prophethood; and the *Sunnah*, all that was narrated from the Prophet Muhammad ﷺ including his sayings, actions, and tacit approvals. The sources on which there is general agreement are the *Ijmaa'*—the unanimous agreement of Muslim jurists of any period following the death of the Prophet Muhammad ﷺ on a topic—and analogical reasoning, in which the Islamic ruling of an original case is applied to a new case on which Islamic law is silent because of an effective cause common to both. Sources upon which there is general disagreement among the scholars regarding their applicability in the derivation of Islamic rulings include: the individual statement of a Muslim who interacted with the Prophet Muhammad ﷺ, the customs of a people at a given time, a scholar's personal juristic preference, the consideration of public welfare that aligns with the objectives of Islamic law, the presumption of continuity of a rational proof that was established in the past, blocking of the means to an expected evil end that is likely to materialize if the means towards it is not obstructed, and laws revealed prior to the advent of Islam. Islamic beliefs surrounding end-of-life care are based on all of these sources, with much use of analogical reasoning, as today's healthcare technology was not available at the time of the compilation of the *Qur'an* and *Sunnah*. However, references to life, disease, and death are present in the texts and are used as guides when considering present-day issues. Physicians are recruited to

explain in detail the medical issue at hand and to discuss the ramifications of potential decisions with judicial experts. In discussions with the medical professional, scholars seek to make the determination that most closely adheres to the spirit of Islamic law. Decisions made using these sources then classify actions as either obligatory, prohibited, recommended, disliked, or permissible (neutral).

The Objectives of Islamic Law

The basis of *Shari'ah* (Islamic law) is in the upholding of five definitive goals: religion, life, lineage, intellect, and property, with precedence given to the preservation of life and religion over the other three.⁴ On this basis, a number of exceptions have been made in order to facilitate the preservation of life. One such exception is the acceptability of physical touch between genders for the assessment and treatment of disease, when the norm is that touch between men and women who are not related is impermissible.

One of Islam's legal maxims—which are useful in depicting a general picture of the nature and objectives of Islamic law—is: “harm is to be eliminated.” This maxim is used frequently in medical decision-making⁵ Variants of this maxim exist. These include “a greater harm is eliminated by means of a lesser harm,” and “a specific harm is tolerated in order to prevent a more general one.” Due to these variants, it is necessary to evaluate the outcome sought from a medical treatment, the likelihood of its achievement, and the risks of the treatment itself, when determining the ruling on any given medical intervention.

Medical Treatment in Islam

The virtue of treating disease is clearly mentioned in classical Islamic texts. An incident is related in which:

*A bedouin asked the Prophet Muhammad: ‘Should we not treat sickness?’
He replied: ‘Treat sickness, for God has not created any disease except that*

⁴ Kamali MH. *Maqasid al-Shariah Made Simple*. Kuala Lumpur, Malaysia: International Institute of Advanced Islamic Studies; 2008:3-7.

⁵ Kamali MH. *Qawa'id al-Fiqh: The Legal Maxims of Islamic Law*. High Wycombe, England: The Association of Muslim Lawyers; 2006:3-4.

He has also created its cure, except for one disease.’ Those around the Prophet asked, ‘O Messenger of God, what is [that one disease]?’ He said: ‘Aging.’⁶

Furthermore, a verse in the *Qur’an* states: “If any saves a life—it is as if he saved the lives of all mankind.”⁷ Based on these and additional proofs, Muslim jurists have classified the seeking of medical treatment into different categories based upon the nature of the illness as well as the anticipated effectiveness of the treatment, as will be discussed below.

Life-Sustaining Measures

While the proofs surrounding general medical treatment are rather clear, rulings pertaining to life-sustaining measures in patient care are not as apparent in Islamic law sources. Hence, the use of analogy is weighed upon heavily when making decisions in this domain. As such, a thorough understanding of such measures, which include artificial hydration and nutrition, is necessary for making a determination on these topics. While artificial nutrition and hydration have clear benefits for certain patient populations, the use of this treatment is not clearly indicated for patients who are in the final stages of their illnesses. The majority of terminally ill patients do not suffer from hunger or thirst.⁸ It is expected that, due to limited brain functioning, patients who are in a persistent vegetative state or comatose do not experience hunger or thirst, in contrast to those who are minimally-conscious and do suffer from pain, hunger and thirst.⁹ Furthermore, artificial nutrition and hydration carry the risk of complications such as aspiration pneumonia and hypervolemia, while not improving the patient’s mental status.¹⁰

⁶ Tirmidhi MI. *Sunan Al-Tirmidhi*. [English Translation]. Houston, TX: Dar-us-salam; 2007: 4/383, no. 1961, 1965.

⁷ *The Quran*. Oxford World’s Classics Ed. New York, NY: Oxford University Press; 2004: 5:32:p.71.

[http://islam24hours.yolasite.com/resources/Quran-Abdel-Haleem- Translation.pdf](http://islam24hours.yolasite.com/resources/Quran-Abdel-Haleem-Translation.pdf). Accessed: November 22, 2013.

⁸ McCann RM, Hall, J, Groth-Juncker, A. Comfort care for terminally ill patients: the appropriate use of nutrition and hydration. *JAMA*. 1994;272:1263–1266. doi:10.1001/jama.1994.03520160047041.

⁹ A.S.P.E.N Ethics Position Paper Task Force, Barrocas A, Geppert C, Durfee SM, Maillet JO, Monturo C, Mueller C, Stratton K, Valentine C, American Society for Parenteral and Enteral Nutrition. American Society for Parenteral and Enteral Nutrition (ASPEN) Ethics Position Paper. *Nutr Clin Pract*. 2010;25:672–679. doi: 10.1177/0884533610385429.

¹⁰ Brody H, Hermer LD, Scott LD, Grumbles LL, Kutac JE, McCammon SD. Artificial Nutrition and Hydration: The Evolution of Ethics, Evidence, and Policy. *J Gen Intern Med* 2011; 26(9):1053-8.doi: 10.1007/s11606-011-1659-z.

Therefore, the rulings associated with withholding and withdrawing artificial nutrition and hydration in both terminally- and non terminally-ill patients will be explored below.

Current State

Sources

Various modern Islamic legislative bodies have amassed proofs from the *Qur'an* and *Sunnah*, and have used analogical reasoning to formulate rulings on issues related to medicine. These groups include the Islamic Fiqh (Legislative) Assembly of the Organization of the Islamic Conference (OIC) and the Islamic Fiqh (Legislative) Assembly of the Muslim World League. Both of these councils are made up of senior scholars who meet periodically to come to conclusions on issues currently facing Muslims worldwide. As mentioned, members of the councils seek input from medical professionals on medical topics.

Findings

Medical Treatment

The default Islamic ruling on seeking medical treatment is that it is permissible, as per the proofs outlined above from the *Qur'an* and *Sunnah*. Furthermore, seeking medical treatment for disease is conducive to the preservation of life, which is one of the main objectives of Islamic law. However, the circumstances of illness, which vary by patient, necessitate particular rulings.¹¹

As per the Islamic Fiqh Assembly of the OIC, the cases in which seeking medical treatment is obligatory include:

- cases in which refraining from medical treatment will lead to significant harm to the patient and/or one of his/her organs, as determined by the

¹¹ Islamic Fiqh Assembly of the Organization of the Islamic Conference (OIC). Decision Number: 67(7/5). Jeddah, Kingdom of Saudi Arabia: May 9th-14th, 1992.

physician in consultation with the patient. In the case of an emergency situation that meets this criterion, the consent of the patient or his/her proxy is not needed for treatment. Consent is necessary in non-emergent cases;

- cases in which refraining from medical treatment will lead to long-term handicap;
- cases in which the patient's disease may be transmitted to others and result in significant harm to them and/or to society, as determined by the physician.

It is recommended to seek medical treatment if refraining from it will lead to weakening of the body, even without the outcomes mentioned above.

It is permissible to seek medical treatment, but not viewed as better than refraining, if none of the above conditions are met.

It is disliked to seek medical treatment if the mode of treatment may cause complications that are deemed more harmful than the illness itself, as determined by the physician in consultation with the patient with the patient's best interests taken into account.¹²

Life-Sustaining Measures

Artificial Nutrition & Hydration

The initiation of artificial nutrition and/or hydration is viewed as a form of medical treatment by Muslim jurists, as they are medical procedures done with the hope of extending life and preserving bodily strength. The physician must weigh the risks and benefits of these interventions in each particular patient—does the net gain from artificial feeding in a patient with little hope of regaining function outweigh the potential losses from its possible complications? For instance, in the case of enteral feeding, delivery of nutrients by way of the GI tract has been shown to maintain physical and immune-mediated barriers and decrease a patient's risk of

¹² Islamic Fiqh Assembly of the Muslim World League. Decision Number: 10(2). Makkah, Kingdom of Saudi Arabia: Oct 17th-21st, 1987.

sepsis.¹³ However, it may also expose a patient to new metabolic, mechanical, and infectious complications.¹⁴ In such a situation, the patient's personal goals from treatment and prognosis must be considered. Enterally feeding a patient with a good prognosis, but who cannot take in food by mouth, is permissible and at times recommended or obligatory in order to avoid the harm of starvation, which may be more likely and detrimental than the potential complications of tube feeding. Alternatively, in a patient with a grim prognosis and/or an incurable disease, the decision for enteral feeding depends on the patient's goals. However, the benefits of artificial nutrition in end-of-life care rarely raise its initiation to the status of recommended or obligatory. It is permissible and at times disliked to initiate tube feeding in such patients, as the potential harms of the intervention often outweigh the possible benefits.

Withholding vs. Withdrawing

Life-sustaining measures, such as artificial nutrition and hydration, are considered differently once they have been initiated. Continuing with the example of tube feeding, a difference in opinion exists on whether delivery of nutrients via enteral access constitutes treatment or simple feeding of the patient. The distribution of nutrients through a tube that is already in place is not perceived as an invasive procedure, as the route has already been made and is considered an alternative to the mouth. Hence, continuing to deliver nutrients enterally is perceived as simply feeding the patient by some experts. However, the fact remains that the contents of enteral nutrition are not ordinary food, but are rather fashioned in a laboratory and optimized on a per-patient basis. This causes some scholars to equate the persistence of enteral nutrition with medical treatment. When it is considered treatment, it is permissible to withdraw artificial nutrition from a patient with little hope of recovery or who is in the terminal stage of his/her disease. However, when it is considered simply feeding, it is prohibited to withdraw enteral nutrition, as this is viewed as starving the patient. Hence, withdrawing an intervention is more problematic than the decision to initiate it, which highlights the importance of

¹³ Kudsk, KA. Importance of enteral feeding in maintaining gut integrity. *Tech in Enteral Access*. 2001;3(1): 2-8. <http://www.sciencedirect.com/science/article/pii/S1096288301800188>. Accessed: December 9, 2013.

¹⁴ Beyer PL. Complications of Enteral Nutrition. In: Matarese, L, Gottschlich M eds. *Contemporary Nutrition Support Practice: A Clinical Guide*. Philadelphia, PA: Saunders; 2003:215-226.

discussions with the patient and/or proxy/surrogate regarding prognosis before performing such procedures.

Palliative Care

Regardless of the incurable or debilitating nature of a disease, it is never Islamically appropriate to take one's own life or to take a patient's life in hopes of saving him/her from suffering. This stems largely from the fact that preservation of life is one of the primary goals of Islamic law and that Muslims believe in a fixed life term that is pre-ordained by God. As humans, including physicians, do not know with certainty the natural progression of any given patient's disease, it is impossible to Islamically justify assisted suicide as a method of easing his/her suffering. Rather, we are encouraged to search for treatment, as in the aforementioned statement of Prophet Muhammad ﷺ: "Treat sickness, for God has not created any disease except that He has also created its cure." Suicide is prohibited in the Qur'anic verse: "And do not kill yourselves [or one another]. Indeed, God is to you ever Merciful."¹⁵

Palliative care offers an alternative to suicide or euthanasia in the face of a disease with a grim prognosis, painful course, and intolerable medication side effects. It involves methods to minimize discomfort without artificially prolonging or truncating the course of an illness. Interventions to tackle pain, respiratory distress, and depression are integral to proper management of illness at the end of life.

Disorders of Consciousness (DOC)

Acute, traumatic medical events in previously healthy individuals are frequently encountered in medicine. In a state between brain death and normal life, the difficult decision of how to proceed in a patient's care must be made. This decision is largely placed on the patient's proxy or surrogate in consultation with the treating physician. The question arises of whether there is, from an Islamic law standpoint, a choice to withdraw life-sustaining interventions that would allow a patient to go on living indefinitely, but in a state in stark contrast to his/her normal

¹⁵ *The Quran*. Oxford World's Classics Ed. New York, NY: Oxford University Press; 2004: 4:29:p.71.
[http://islam24hours.yolasite.com/resources/Quran-Abdel-Haleem- Translation.pdf](http://islam24hours.yolasite.com/resources/Quran-Abdel-Haleem-Translation.pdf). Accessed: August 28, 2017.

life. The qualities that define a normal human life have been put forth by scholars and may be used to guide this decision. Jurists define life as the combination of input and output—input may be quantified as a patient’s awareness of his/her self/environment and reception of ideas. Output is a person’s own will, which may be manifested by purposeful action or communication. If both of these components are not present, then the person is not considered to be living a normal human life. There is no division in classical Islam of life into normal human and vegetative/artificial. Hence, a life devoid of either input or output is equated by Muslim jurists to the life of an embryo before it has been given its soul.¹⁶ Rulings of killing do not apply to such a state because it is not a normal human life to begin with.

Disorders of consciousness are separated into three levels: coma, vegetative state (VS), and minimally conscious state (MCS). Patients in coma and VS have no measureable awareness of self/environment and no purposeful behavior. The differentiation between the two lies in the presence of sleep/wake cycles in VS and their absence in coma. Coma generally lasts 2-4 weeks and progresses to recovery, transitions to VS, or death. VS is deemed “persistent” when it lasts for 1 month or longer. VS is deemed “permanent” when it extends past 3 months after a nontraumatic brain injury and for 12 months after a traumatic brain injury. MCS is characterized by evidence of self and/or environmental awareness as well as reproducible purposeful behaviors. It is important to note that patterns of emergence from disorders of consciousness vary widely across patients and that prognosis is very difficult to characterize in the acute phase of an injury.¹⁷

Coma and VS show little evidence of normal, sustainable human life as they are devoid of input and output. Hence, if a patient’s coma or VS is deemed irreversible (such as a permanent VS), based on the judgment of three specialty-trained physicians, it is considered permissible by most jurists to withdraw this patient’s life-sustaining measures. An MCS is considered a normal, sustainable human life,

¹⁶ Al-Haj, Hatem. *The Impact of Medical Advancements on Religious Edicts and Judgeship*. [dissertation, Arabic]. Tripoli, Lebanon: al-Jinan University; 2008. p.103.

¹⁷ Cuccurullo, SJ. *Physical Medicine and Rehabilitation Board Review, 2nd Edition*. Edison, NJ: Demos Medical Publishing; 2010. 55-56.

and this condition is treated as a general medical illness when considering withdrawing life-sustaining measures. An MCS in itself is not considered a condition with a grim prognosis. However, medical conditions that a patient may have in association with the MCS (e.g., a severe antibiotic-resistant infection) may lower the patient's potential for overall recovery and make life-sustaining measures futile. Again, this must be concluded by three qualified physicians, at which point life-sustaining measures may be withdrawn. In cases in which withdrawal of life-sustaining measures is permissible, it is not obligatory to do so. The decision to continue or withdraw life-sustaining measures in these cases should be based on the surrogate/proxy's perception of the patient's wishes. It is critical in DOC that the physician properly educates the patient's surrogate or proxy on the likelihood of emergence and subsequent prognosis based on the available evidence.

Brain Death

A question that frequently arises in discussions around medical interventions in the context of Islamic jurisprudence is the validity of brain death as a declaration of death. The American Academy of Neurology guidelines for brain death determination include two separate neurologic exams performed by trained physicians in the absence of reversible causes of cognitive depression (e.g., hypotension, hypothermia, electrolyte abnormalities, intoxicants). The evaluation necessitates an absolute lack of responsiveness, including to painful stimuli, an absence of brainstem reflexes, and an absence of respiratory drive.¹⁸ Ancillary tests, including an electroencephalogram (EEG), cerebral angiography, transcranial doppler ultrasonography, and cerebral scintigraphy may be used to confirm brain death. In its statement regarding the permissibility of withdrawing life-sustaining measures in a person deemed brain-dead, the Islamic Fiqh Assembly of the Muslim World League decided in 1987:

It is permissible to turn off the life support systems of a patient whose brain has completely stopped functioning on condition that a committee of three

¹⁸ American Academy of Neurology Guidelines for Brain Death Determination. University of Miami Health System: Miller School of Medicine. Available: <http://surgery.med.miami.edu/laora/clinical-operations/brain-death-diagnosis>. Accessed August 22, 2017.

*specialized expert doctors decides that the cessation is final and irrecoverable. Such permissibility is valid even if the heart and respiratory systems are still functioning mechanically due to the life support systems. However, the legal judgment of death is not declared until it is assured that the heart and respirations have fully stopped after turning off all the life support systems.*¹⁹

This declaration does not equate brain death with death, but rather states that death can only be declared upon the cessation of vasomotor and respiratory functions, regardless of whether those are being artificially sustained. Furthermore, it raises a stipulation that is generally not ascertained during the routine brain death evaluation: that a brain-dead patient's *whole* brain has stopped functioning. The standard brain death exam that physicians perform typically evaluates specifically for brain stem function, which is considered representative of the viability of the rest of the brain. The special testing mentioned above, such as EEG to ascertain the presence of meaningful brain function and vascular studies of the brain to evaluate for adequate blood flow that is compatible with life, would provide more information on the condition of the whole brain than the brain death exam alone, and may be requested by the Muslim patient's family.

Advanced Directive

An advance directive is drafted while a person is of sound mind and states his/her wishes about health care should he/she be afflicted with a critical illness or incapacity. As long as it conforms to the guidelines detailed above, it is recommended for a Muslim to have an advance directive, as it typically eases decision-making for the patient's family during a time of difficulty. One component of advance directives is the "Do Not Resuscitate" (DNR) order, which communicates whether the patient wishes to have cardiopulmonary resuscitation (CPR) performed in the event that his/her heart stops beating. CPR is considered a form of medical treatment. A patient whose body has weakened at baseline and whose illness has a grim prognosis likely does not require resuscitation in the event

¹⁹ Islamic Fiqh Assembly of the Muslim World League. Decision Number: 10/2. Makkah, Kingdom of Saudi Arabia: Oct 17th-21st, 1987.

of cessation of vasomotor function, from an Islamic perspective. In such a situation, the potential harms and limited benefits of CPR may downgrade its initiation to “disliked.” Similar to the initiation of artificial nutrition and hydration, the potential benefits of resuscitation are minimal in this scenario. A 2009 study showed that only 18% of adults aged 65 and older survived to hospital discharge following in-hospital CPR.²⁰ A 2012 study found that only 2-5% of adults who underwent CPR in the field had good functional outcomes—defined as no, minimal, or moderate neurological disability—one month after the event.²¹ Hence, CPR is associated with its own morbidity and its outcomes vary as a function of the patient’s previous condition. CPR for a young, previously healthy patient is generally encouraged due to its higher likelihood for positive outcomes.

Concluding Remarks

Life-sustaining measures are often explored from a spiritual or religious perspective by patients and their families. An understanding of the factors influencing a patient’s or proxy’s decision can help the physician in his/her role as a guide in such a situation. Guided by the goal of limiting harm in Islamic jurisprudence, the decision to initiate life-sustaining measures varies from obligatory to disliked depending on the specific situation of each patient, while the decision to withdraw such interventions is often more difficult to justify Islamically. In contrast to a terminally ill patient with a grim prognosis, a patient with an altered level of consciousness (characterized by lack of awareness of self/environment and no purposeful movements/communication), who may survive indefinitely with artificial interventions, may be withdrawn from such interventions once the patient’s condition is deemed irreversible, per the proxy’s informed and patient-centered decision. Brain death is not equated to death by one group of jurists, but the declaration of brain death indicates that life-sustaining measures may be withdrawn, allowing the patient’s heart and lung functions to cease on their

²⁰ Hagihara, et al. Prehospital Epinephrine Use and Survival Among Patients With Out-of Hospital Cardiac Arrest. *JAMA*. 2012;307(11):1161-1168.

²¹ Ehlenbach, et al. Epidemiologic Study of In-Hospital Cardiopulmonary Resuscitation in the Elderly. *N Engl J Med* 2009;361:22-31.

own. Palliative care interventions are important options for Muslim patients at the terminal state of illness, as euthanasia is prohibited in Islam. The physician's role in explaining the patient's prognosis and the benefits and harms of specific interventions is critical in allowing the patient, proxy, or surrogate to make the most appropriate decision of care in accordance with their Islamic beliefs and the patient's previously established wishes.