MAQASID AL-SHARIAH AND BIOMEDICINE

BRIDGING MORAL, ETHICAL, AND POLICY DISCOURSES

AASIM I. PADELA

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IIIT

LONDON • WASHINGTON

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Library of Congress Cataloging-in-Publication Data

Names: Padela, Aasim I., author. | International Institute of Islamic Thought, issuing body.
Title: Maqasid al-shariah and biomedicine : bridging moral, ethical, and policy discourses / Aasim I. Padela.
Description: Herndon, VA : International Institute of Islamic Thought, [2024] | Includes bibliographical references and index.
Identifiers: LCCN 2024042587 | ISBN 9798891932272 (hardback) | ISBN 9798891932289 (paperback) | ISBN 9798891932296 (pdf)
Subjects: MESH: Religion and Medicine | Islam | Bioethics
Classification: LCC BP166.72 | NLM BP 166.72 | DDC 297.2/661--dc23/eng/20241119
LC record available at https://lccn.loc.gov/2024042587

Layout and design by Shiraz Khan

Printed in the USA

Contents

List of Tables vi
Endorsements vii

FOREWORD ix

PREFACE xiii

INTRODUCTION — THE WHO, WHAT, WHY, AND WHERE TO 1

1. Biomedicine and Contemporary Healthcare: Delineating the Problem-Space and Context 9
2. An Overview of *Maqāṣid al-Sharīʿah* Frameworks: Describing the Tools 21
3. A *Maqāṣid*-Based View of Human Health: Identifying the Goal(s) 44
4. A *Maqāṣid*-Based Health Policy Agenda: Structuring Society to Achieve the Goal(s) 58
5. *Maqāṣid*-Based Models for Clinical Medical Ethics: Moral Deliberation at the Bedside 72
6. The Crucible of a "Brain-Dead" Pregnant Woman: Do *Maqāṣid* Frameworks for Medical Ethics Meet the Challenge? 88
7. Preserving Life or Preserving Religion? The Highest Objective in Healthcare 111
8. Conclusion: The Perils and Promise of Integrating *Maqāṣid* in Biomedicine 130

ENDNOTES 150
BIBLIOGRAPHY 183
INDEX 203

LIST OF TABLES

2.1 *Relationships between Objectives, Wisdoms and Human Interests*

2.2 *The Higher Objectives According to Imam al-Shāṭibī and Prof. Gamal Eldin Attia*

5.1 *A Typology of Islamic Bioethics Consumers and Their Needs*

5.2 *A Typology of Islamic Bioethics Producers and Their Primary Roles and Outputs*

ENDORSEMENTS

DR. DANIEL SULMASY

Director of the Kennedy Institute of Ethics, Georgetown University, USA

Aasim I. Padela has a perhaps unique command over both Islamic thought and biomedicine. In this book he delivers precisely what the Muslim world needs to address contemporary bioethical issues credibly but faithfully, and also what bioethics needs from the Muslim world. It is written in a manner that is accessible to non-Muslims but deeply engaged with the highest standards of Islamic tradition and scholarship. This book is an impressive achievement, and it will prove an incredibly useful resource for years to come.

DR. JASSER AUDA

Visiting Distinguished Professor, International Institute of Islamic Thought and Civilization (ISTAC-IIUM), Malaysia
Chairman, Maqasid Institute for the Studies of the Quran (MISQ), Canada

It is great news that the seminal application of *maqāṣid* thought to the field of medicine that Dr. Aasim Padela has been doing over the years is now expressed in a book. The way forward for applied Islamic 'Ijtihad' (i.e., original scholarship) is not to create a destructive conflict between scholars of tradition, who are beholden to inherited 'older' views of society and may not see their perspectives on present reality as limited, and scholars of specialization, who are trained within a secular worldview and consider that their knowledge is "technical" and/or "ethical" while it is not. Rather, the way forward is for the scholars of Islam: (1) to have a firm basis in the foundations of Islamic scholarship: the Quran and the Sunnah, (2) to be aware of the inherited Islamic knowledge related to their field(s) of investigation, (3) to take a critical – and fair – approach to contemporary non-Islamic knowledge, and finally (4) to develop a purpose-driven, trans-disciplinary, comprehensive and integrative research methodology. I believe Dr. Aasim is doing just that.

DR. KHALIL ABDUR RASHID

Muslim Chaplain at Harvard University
Islam and Public Policy Lecturer at the Kennedy School of Public Policy
Chair of the Board of Religious, Ethical and Spiritual Life at Harvard University, USA

Dr. Padela's pioneering work *Maqasid al-Shariah Meets Biomedicine*, is a much-needed scholarly contribution to the intersection of Islam and biomedicine. Written for Muslim professionals and clergy, policy makers and thinkers, civic leaders and students, this book maps the landscape of how Islamic biomedicine would fundamentally shape contemporary healthcare and outlines the theoretical tools necessary for an Islamic framework for addressing biomedical issues. Interdisciplinary in its scope, it's also a contribution to the enhancement and development of the theory of *maqāṣid*, outlining the ways in which *maqāṣid*-based thinking and analysis may better shape decision making for improved public health outcomes to save lives. Practical in its appeal, bold in its pursuits, Dr. Padela's work gets to the heart and spirit of the real-world implications of Islam and biomedical applications.

ENDORSEMENTS

PROFESSOR MOHAMMAD HASHIM KAMALI

Founding CEO and currently Adjunct Fellow of the International Institute of Advanced Islamic Studies (IAIS) Malaysia

Dr. Padela's seminal book offers a reading of the *maqāṣid* in conjunction with modern biomedicine exploring the prospects of a revised healthcare policy that is based on *maqāṣid*. The author suggests detailed strategies yet also many challenges that integration of the religious values of *maqāṣid* into the secularist agenda of modern biomedicine would present. He speaks in remarkably pragmatic yet elegant language that merits consideration by students and specialists of both the *maqāṣid* and biomedicine. He tells the reader of the potential benefits yet also uncertainties that need to be addressed in order to achieve the suggested integration. The author maintains that integration is the way forward and should be the working agenda of a better structured and more purposeful contemporary biomedicine.

PROFESSOR TARIQ RAMADAN

Retired Emeritus Professor of Contemporary Islamic Studies, University of Oxford, UK

Dr. Aasim Padela's book is a critical contribution to *maqāṣid al-sharʿīah* and biomedicine. Discussing the traditional and contemporary approaches of *maqāṣid*, Dr. Padela raises essential questions about the definition of health (beyond the reductive Western scientific norms) and the understanding of both Islamic epistemology and applied Islamic ethics in biomedicine. This is a timely and necessary call for caution for any Muslim scholar or practitioner not to neglect the Islamic spiritual meanings and rules in the name of flawed use of the higher objectives' theories.

PROFESSOR WILLIAM SCHWEIKER

Edward L. Ryerson Distinguished Service Professor of Theological Ethics
The University of Chicago Divinity School, USA

In this excellent book, Dr. Aasim Padela not only establishes himself as a leading thinker in Islamic bioethics, but also, and importantly, a voice at the intersection of religion, bioethics, and policy. This volume is essential reading for anyone interested in a learned and insightful examination of that intersection of topics. I hope this volume gets the attention it rightly deserves and also that Dr. Padela's work opens new paths in bioethics.

SHAYKH DR. YASIR QADHI

Dean, The Islamic Seminary of America
Resident Scholar, East Plano Islamic Center, Dallas, Texas, USA

Like Dr. Padela himself, this text straddles the worlds of Islam and biomedicine, aspiring to deliver a more morally upright healthcare. Merging nuanced analyses with expert 'insider' knowledge of the workings of Islamic law and the paradigms and practices of contemporary healthcare, the book is a foundational must-read for Muslim scholars and physicians alike. It takes a measured tone in critiquing the current use of *maqāṣid* frameworks in Islamic bioethics but offers avenues for sophisticated right-ordering of *maqāṣid* tools within a comprehensive Islamic bioethical framework alongside *fiqh*, *uṣūl*, *kalām*, and *adab*. Moving beyond deliberation, Dr. Padela also offers ways in which *maqāṣid* values may inform health policy action and healthcare system design.

FOREWORD

In the quest for a dialogue between the moral foundations of Islamic jurisprudence and the policy frameworks and practices of contemporary healthcare, Padela explores and critiques the legitimacy and feasibility of applying a *maqāṣid* approach, calling for multidisciplinary engagement with multi-tier moral evaluation. He explores such questions as how and why might the *maqāṣid al-Sharīᶜah* be relevant to contemporary biomedicine? What do theories of *maqāṣid al-Sharīᶜah* have to say about individual health and societal well-being? How might values and interests represented by the *maqāṣid* inform healthcare practices and policies? Can *maqāṣid* frameworks furnish an Islamic approach to bioethical decision-making?

He makes two key observations: a) that the "genre of ethico-legal reflection (provided by the *maqāṣid*) is attractive to scholars seeking to modernize Islamic thought because it is believed to offer a corrective for Islamic rulings (fiqh) that are seen as formulaic and inflexible." The posited "openness" of *maqāṣid* frameworks to natural and social scientific data and to utilization by non-specialists in Islamic law further bolsters their allure as a site for reform. He further notes that b) reformers "champion the development of *maqāṣid*-based frameworks to allow the inherited Islamic ethico-legal canon to extend its reach to modern contexts," with one of those modern contexts being biomedicine.

Rapid advancements in modern medicine and healthcare pose significant challenges for Islamic scholars. Jurists, legists, imams, and chaplains are tasked with helping the polity navigate complex and critical issues, such as end-of-life healthcare decisions, including in cases of "brain death." The definition of brain death is in itself controversial both from a biomedical as well as a religious standpoint and becomes even more charged when evaluating the permissibility of

discontinuing life support for a pregnant woman who may have suffered brain death whilst the foetus is still alive (a case Dr. Padela takes up in the book). Additionally, novel techniques of organ donation and transplantation, some of which hinge upon the diagnosis of brain death, as well as strange new reproductive technologies such as ectogenesis, provide further unchartered territories necessitating cogent moral and ethical analysis. Islamic scholars must take on the crucial responsibility of providing comprehensive guidance and cogent fiqh positions on these important and intricate matters and doing so whilst considering the principles of Islamic law and the complex contexts of contemporary healthcare.

Padela recognizes the strengths and weaknesses of the juristic responses to date. By returning to the foundations of Muslim juridical theology, Islamic scholars have been able to uncover key principles of Muslim moral philosophy that speak directly to the fundamental questions surrounding human health and the critical role that medical professionals play in providing appropriate, equitable healthcare to all. At the core of the Islamic moral framework is the sanctity of human life, which necessitates a profound respect for the dignity and well-being of every individual. The important point to note is that a *maqāṣid*-based approach emphasizes the protection of fundamental human interests, such as life, religion, intellect, family, and property, while also considering the overall welfare and harmony of society. This ethos aligns closely with the contemporary healthcare policies that prioritize patient-centered care. That said, according to the author, Western bioethics principles do not sufficiently account for Muslim concerns in clinical ethical decision-making, whilst Islamic juridical practices face their own problems and need to expand to offer a broader methodology that speaks to a global audience.

Thus, Padela critiques attempts to ground ethical positions in the *maqāṣid* alone with extant interpretations and applications falling short of a nuanced, comprehensive understanding. He contends that some scholars, for instance, take an overly simplistic approach, treating the

maqāṣid as principles without fully grappling with their deeper philosophical underpinnings and overlooking key contextual complexities. This results in religious interpretations that may be superficially aligned, but at a deep level misaligned with an authentic Islamic moral vision. Moreover, there is a failure to account for the rich tapestry of Islamic jurisprudence and moral reasoning. Others, he notes, have adopted an eclectic approach, juxtaposing *maqāṣid* concepts with Western bioethical frameworks, resulting in a disjointed and potentially problematic synthesis. And then there are scholars who lambast all *maqāṣid* approaches altogether.

Padela calls for meaningfully bridging the discourse between these elements – Islamic ethics, juristic theology, and contemporary healthcare – to explore a more rigorous and contextually grounded engagement with the *maqāṣid*. Such work necessitates a deep study of the classical and modern scholarship on the subject, exploring the intricate web of principles, priorities, and interpretive methodologies that underpin the *maqāṣid*, and for incorporating a multi-disciplinary engagement in understanding both the religious and the biomedical. With reference to the latter, he also acknowledges the potential for conflict, arguing that we need to mark out the degree of influence medical professionals and other specialists exert in the ethical deliberation and determine the threshold for involvement that would be deemed as excessive interference or exceeding moral authority.

Maqāṣid al-Sharīᶜah is a fundamental concept in Islamic jurisprudence that focuses on the higher objectives and purposes of Islamic law. Padela provides a lucid exposition of the concept summarising its origins and historical development. What is clear is that Muslims need to cultivate a more robust, holistic, and contextually sensitive framework for addressing the ethical dilemmas, policy issues, and practice concerns facing the healthcare sector in the modern age. Whilst frameworks built upon the *maqāṣid al-Sharīᶜah* have the potential to revitalize Islamic ethical and legal scholarship, fully capitalizing on this potential requires, in his view, and among other

elements, that the Qur'an is used to identify legitimate human interests that must be preserved; and multidisciplinary analyses of both scripture and society are conducted so that holistic understandings of Islamic morality and the contemporary problem-space emerge.

This study is invaluable to scholars, health care professionals and general readers. Where dates are cited according to the Islamic calendar (hijrah) they are labelled AH. Otherwise they follow the Gregorian calendar and labelled CE where necessary. Arabic words are italicized except for those which have entered common usage. Diacritical marks have been added only to those Arabic names and terms not considered modern.

Since its establishment in 1981, the IIIT has served as a major center to facilitate serious scholarly efforts. Towards this end it has, over the decades, conducted numerous programs of research, seminars, and conferences as well as published scholarly works specializing in the social sciences and areas of theology, which to date number more than six hundred titles in English and Arabic, many of which have been translated into other major languages.

We thank the author, the editorial team at the IIIT London Office and all those directly or indirectly involved in the completion of this book. May God reward them all for their efforts.

IIIT LONDON OFFICE
AUGUST 2024 CE

PREFACE

Muslim thinkers, be they seminarians, academicians, or scientists, are increasingly expanding the paradigm regarding how they address contemporary social, political, and moral challenges by using frameworks built upon the higher objectives of Islamic law, the *maqāṣid al-Sharīʿah*. Many reasons underlie the attractiveness of the *maqāṣid* to these scholars and professionals: fiqh and *fuqahā'* appear to fall short in addressing modern social, scientific, and political realities, transnational ethical and political discourses marginalize scripture-based arguments, and the relatively straight-forward logic of *maqāṣid*-based reasoning makes it accessible to diverse audiences. As *maqāṣid* thought has gained popularity, Islamic scholars strive to rework classical schema for the higher objectives; and Muslim researchers, social scientists, and policymakers have begun to employ tools based on *maqāṣid* frameworks and concepts. While this phenomenon has received some critical attention from researchers in finance and politics, relatively little attention has been given to how the *maqāṣid* interface with biomedicine and contemporary healthcare.

This monograph attends to this scholarship gap by exploring discursive links between the *maqāṣid* and contemporary biomedicine. As the introduction further details, this book outlines several areas for critical engagement of *maqāṣid* thought with the concepts, goals, practices, and social structures of biomedicine. It sketches out possibilities of how *maqāṣid* frameworks might work with biomedicine but also demarcates the limitations of current approaches so as to spur intellectual development at the intersection. Indeed, by sketching out the promise and peril of how *maqāṣid* frameworks might influence biomedicine and contemporary healthcare, it is hoped that this book motivates scholars to refine *maqāṣid* theories, update *maqāṣid* implementation frameworks, and conduct applied research into how well *maqāṣid* approaches solve contemporary bioethical challenges.

The seeds for this project were sown over a decade ago shortly after I had reviewed the extant writings of prominent Muslim physicians and the fatwas of leading Islamic jurists in order to understand how my practice of medicine could be shaped by Islamic morality. That personal quest blossomed into an academic line of inquiry examining the compatibility, commensurability, and conflicts between the ontological, epistemic, moral, and ethical frameworks of the Islamic tradition and biomedicine.

My studies revealed an interesting problem: both jurists and physicians would regularly refer to the higher objectives of Islamic law, the *maqāṣid al-Sharīʿah*, to advance moral visions for biomedicine, yet these thinkers had different views about what the *maqāṣid* were and how they should be utilized. Encouraged by mentors and interlocutors, and equipped with some modest grant funding, I set out to explore the relevance of the *maqāṣid* to biomedicine.

This project's journey has been long, with many individuals facilitating my work, helping me solve intellectual puzzles, and tutoring me on the subject. I am deeply grateful to all who have aided me along the way. Some individuals deserve specific mention as they were especially invaluable and gracious. I recall an initial meeting with Shaykh M. Amin Kholwadia of Darul Qasim in 2009, where I voiced my interest in studying the *maqāṣid al-Sharīʿah* to link fiqh and practical ethics in Islamic bioethics. Instead of the *maqāṣid*, he gently nudged me toward studying theology as we examined Islamic bioethics discourses. I am indebted to him for his teaching, counsel, critical insights, and overall support of my intellectual and spiritual quests. I also recall, around that time, attentively reading Prof. Tariq Ramadan's book, *Radical Reform: Islamic Ethics and Liberation*, where he advocated a "radical" approach to renewing Islamic ethics by developing field-specific *maqāṣid* through the combined efforts of "scholars of the text" (i.e., Islamic jurists and theologians) and "scholars of the context" (i.e., experts in the natural and social sciences). A chance encounter with him at a Muslim convention led to a collegial

relationship that spanned several years during his tenure at Oxford University and the Research Center for Islamic Legislation and Ethics (CILE) in Doha. His generosity of spirit and commitment to Islamic ethics were displayed at a meeting at St. Antony's College during my time as a visiting fellow at the Oxford Centre for Islamic Studies. While I spent most of that meeting critiquing his optimistic view of collective ijtihad in Islamic bioethics, I left that meeting with an invitation to join a group of scholars working on issues of bioethics at his *maqāṣid*-focused center in Doha.

Others deserve my profound gratitude as well: Prof. Jasser Auda, for graciously attending to many queries about the various theories of *maqāṣid al-Sharīʿah*, reviewing my research-in-progress and strongly encouraging me to continue this book project despite many obstacles; Prof. Ovamir Anjum, for being a gracious interlocutor as I developed my ideas; and Chaplain Khalil Abdur-Rashid, who provided helpful feedback on early drafts of this monograph. I also want to thank former leaders at the International Institute of Islamic Thought (IIIT), particularly Drs. Ermin Sinanović and Abubaker Al-Shingieti, for hosting me as I put together the critical parts of this manuscript during my term as a visiting research scholar there in 2016.

Notably, much of the research conducted for this book was funded by the John Templeton Foundation through the Enhancing Life Project at the University of Chicago. I am indebted to the foundation and the project's principal investigators, Profs. William Schweiker and Günter Thomas for their trust and sage insights along the way. I also thank all of my Enhancing Life colleagues for their friendship while acknowledging two, Dr. Dan Sulmasy and Prof. Jeffrey Haynes, for their helpful comments on an initial version of this monograph. I am also grateful to my colleague, Dr. Don Fette, for his expert wordsmithing and editorial assistance in compiling the book. Thérèse Wassily Saba's assistance in this domain is also much appreciated. I also thank Racha Alsharef and Obay Altaleb at IIIT Press for

trusting me to complete this project and shepherding the work through external review.

Finally, I owe a deep gratitude to my life partner, Maryam. She has been a rock of refuge during my stormy journey within the academy, and has consistently sacrificed her aspirations to facilitate my unconventional research pursuits. Perhaps she foresaw this work, as she gifted me a book on the *maqāṣid* shortly after I graduated medical school. Thank you most dearly. I also appreciate my children, Aaleeyah, Maaria, Ahmed Fateh, and Faathima, who inspire and support me to conduct scholarship at the intersection of Islam and society.

Finally, the utmost praise and thanks are given to Allah, Who enables, facilitates, and creates everything. May He accept this work as a continuous charity and make it a means for success on the Day of Reckoning, and may He send salutations upon Prophet Muhammad, (ṢAAS) * who opened paths of knowledge toward Allah and felicity for us.

Ameen.

* (ṢAAS) – *Ṣallā Allāhu ʿalayhi wa sallam*. May the peace and blessings of God be upon him. Said whenever the name of Prophet Muhammad is mentioned.

INTRODUCTION: THE WHO, WHAT, WHY, AND WHERE TO

What Is This Book About?

In recent years, discussions about the *maqāṣid al-Sharīᶜah*, often rendered "the higher objectives of Islamic law," have become commonplace within Muslim public, professional, academic, and policy circles. For example, it is routine for Muslim periodicals to discuss how economic policies and human development programs accord with the higher objectives of Islamic law.[1] Broad professional interest in the topic is witnessed by both brick-and-mortar institutes and online academies alike. The Riphah International University in Pakistan and the Al-Furqan Heritage Foundation in the United Kingdom are examples of the former,[2] and the Islamic Institute for Development and Research and Maqasid Institute of the latter;[3] these institutions offer courses on the *maqāṣid al-Sharīᶜah* to meet the needs of learners seeking to understand how the *maqāṣid* intersect with their religious practices and professional identities. Additionally, conferences and workshops hosted by institutions such as the International Institute of Advanced Islamic Studies in Malaysia and the Research Center for Islamic Legislation and Ethics in Qatar speak to the growing academic interest in delineating how *maqāṣid al-Sharīᶜah* frameworks interface with contemporary economic, social, and political issues.[4] This flurry of activity and diversely spread engagement is further reflected in an increasing number of journal articles and books dedicated to the *maqāṣid al-Sharīᶜah*.[5] This book adds to the growing body of scholarship by exploring connections between the *maqāṣid* and contemporary biomedicine.

But what are the *maqāṣid al-Sharīʿah*, and why are they relevant today? The term *maqāṣid al-Sharīʿah* refers to a variety of interrelated items pertaining to Islamic legal theory, and there are many reasons that scholars and thinkers find the schema alluring. Most directly, the term refers to a catalog of overarching human interests that Islamic law is purported to serve, a sort of ethico-legal axiology. Preserving and protecting these interests is generally considered to be the core rationale underpinning every Islamic ruling, though the linkage may not always be straightforward or apparent. Although there is broad agreement that Islamic law functions to preserve human interests and that these interests are accessible to human reason, there is significant debate about these specific interests and how they are to be identified, categorized, and utilized. Consequently, multiple frameworks for the *maqāṣid al-Sharīʿah* have been used by Islamic scholars throughout the ages. As such, the term can refer to the theoretical notion of the existence of higher objectives to Islamic law, to a particular *maqāṣid* framework, or to a specific set of human interests that have been delineated. Chapter 2 will delve into the scholarly debates and differential usage of the term; for now, the reader should note that the *maqāṣid al-Sharīʿah* refers to a set of connected theories, frameworks, and catalogs of human interests associated with Islamic law.

Most certainly, the *maqāṣid al-Sharīʿah* are a current 'hot' topic, and this heightened interest is informed by many historical, practical, and social factors. Notably, many view the *maqāṣid al-Sharīʿah*, or more specifically frameworks based on the idea that there are concrete, rationally accessible overarching objectives to Islamic law, as resources by which the Islamic tradition (and thereby Muslim polities) may engage with the exigencies of modern life authentically and in a forward-looking manner. Authenticity is conferred by the *maqāṣid* being tied to scriptural sources and linked to intellectual giants within the classical tradition. *Maqāṣid* frameworks are touted to be forward-looking because they are adaptable to changing social contexts and can be implemented by non-specialists in Islamic law.

Consequently, Muslim thinkers from diverse backgrounds have described and expanded upon the classical theories of *maqāṣid al-Sharīʿah* and developed frameworks and resources based on these for ethical, political, and social ends.

This monograph adds to existing scholarship by analyzing the interface of *maqāṣid*-based models with aspects of modern biomedical theory, practice, and policy through the writings of several classical and contemporary *maqāṣid al-Sharīʿah* theorists. It aims at initiating a multifaceted, interdisciplinary conversation between the Islamic ethico-legal tradition and biomedicine,[6] using the *maqāṣid* as a vehicle for discourse between the two. Given this purpose, this book does not comprehensively detail all the historical and conceptual connections between the *maqāṣid* and biomedicine, nor is it an authoritative manual delivering a full-fledged model for bridging Islam and biomedicine. Instead, it provides the reader with an initial yet detailed attempt to address several related questions: Why and how might the *maqāṣid al-Sharīʿah* be relevant to contemporary biomedicine? What do theories of the *maqāṣid al-Sharīʿah* have to say about individual health and societal well-being? How might values and interests represented by the *maqāṣid* inform healthcare practices and policies? Can *maqāṣid* frameworks furnish an Islamic approach to clinical ethics decision-making? Although the answers within its pages are provisional, this book nonetheless lays down the necessary foundations for scholarly engagement with these pressing questions.

Why This Book?

As highlighted above, the *maqāṣid al-Sharīʿah* are of increasing interest to professionals and policymakers. These two groups' specific interest is in addressing contemporary challenges by applying solutions sourced from the classical Islamic tradition to them. The perceived utility of the *maqāṣid* thus emerges against the larger backdrop of "Islamicization,"[7] where Muslim stakeholders seek religious

guidance on and approval to participate in numerous social practices and institutions from financial services to the food industry due to perceived disconnects between their religious values and modern life.[8] The *maqāṣid* are thus a mechanism for maintaining religious oversight and identity in an increasingly secular age.

In order to use the *maqāṣid* for such purposes, it is of paramount importance to trace the lineage of *maqāṣid* thought and to describe concepts and theories connected to them. Many legal scholars have taken up this task,[9] while the more practice-oriented scholars have focused on the applicability and implementation of *maqāṣid* frameworks to distinct fields and on analyzing related social, ethical, and policy questions. This literature is comparatively smaller and primarily focuses on issues of banking and finance.[10] Indeed, only a few scattered writings pertain to the intersection of *maqāṣid* and biomedicine.[11]

This book thus fills in critical knowledge and literary gaps related to the relevance of Islamic values (through the *maqāṣid*) to contemporary society. Biomedicine is a particularly fertile site for this sort of exploration for three reasons. First, biomedical advancements and technologies push conceptual and practical boundaries related to humanity and society in ways perhaps no other field does. For example, practical boundaries that distinguish a living from a dead individual are stretched by concepts such as "brain death."[12] Similarly, time-honored understandings of parenthood are reconfigured through assisted reproductive technologies and gestational surrogacy arrangements.[13]

Second, societal problems are increasingly conceptualized and addressed through biomedical models. For example, gun violence is now viewed as a public health epidemic requiring community-based and health system-driven violence prevention programs; childlessness is relabeled as the disease of infertility requiring biomedical solutions that go above and beyond social arrangements such as adoption; a lack of access to food and jobs is reframed as deprivation of social determinants of health leading policymakers to mandate

hospital systems help solve these issues. The biomedical model is a significant cultural force; some would argue it holds too much motive power in society today. Indeed, the French philosopher and social theorist Michel Foucault provocatively asserted that ours is an era where nation-states engage in practices of "biopower" to regulate and control all aspects of human health and where "biopolitics" is on display to rightly order human life.[14] Exploring how the *maqāṣid* interface with biomedical approaches to societal problems is relevant to uncovering biases underlying how Islam and societal issues are conceptualized.

A third reason to examine relationships between the *maqāṣid* and biomedicine is that, contrary to other aspects of secular society within healthcare and bioethics, religion is part of the conversation. Healthcare providers often take into account the religious needs and spiritual health of their patients as part of their mandate for culturally sensitive and patient-centered healthcare,[15] some global bioethics discourses acknowledge that religious traditions are fonts of wisdom and ethical practices,[16] and, at times, health policymakers recognize the need to engage religious leaders in dialogue to promote health.[17] Given the purchase religion already has within biomedicine, *maqāṣid* frameworks may be more amenable for uptake in this domain, and exploring commensurability between the two value systems is immensely instructive.[18]

Where Will This Book Take the Reader? An Overview

This book contains eight chapters and unfolds in the following way. In Chapter 1, I introduce the problem-space we will apply *maqāṣid*-based models to, biomedicine. Here I discuss biomedicine as a body of knowledge, a societal approach to human maladies, and a set of practices. I also describe the social structuring of healthcare systems to set the stage for the following chapters, each of which analyzes how the *maqāṣid* may inform biomedicine. In Chapter 2, I introduce the

reader to the 'tool' for approaching biomedicine, the *maqāṣid al-Sharīcah*. I describe what the *maqāṣid* represent, define key terms and concepts of this Islamic ethico-legal theory, and summarize the *maqāṣid al-Sharīcah* models developed by two leading theorists, Imam Abū Isḥāq al-Shāṭibī (d. 790/1388), a fourteenth-century Sunni legal theorist and scholar of the Maliki school of law, and Prof. Jamal al-Din cAtiyah (b. 1928 CE), a contemporary Islamic legal theorist.

Chapter 3 tackles theory: I use the *maqāṣid* formulae of al-Shāṭibī and cAtiyah (Attia) to build up the essential dimensions of human health. One could argue that these dimensions of health set up the goals that healthcare systems must advance at the individual and societal levels. From an Islamic ethico-legal perspective, arguably, providing these essentials becomes a moral obligation. This chapter also connects Chapters 1 and 4 by commenting on determinants of health and healthcare system design. Chapter 4 moves from theoretical visions to the practical structuring of society as I use the aforementioned two *maqāṣid* models to describe a health policy agenda addressing the leading causes of human mortality. I contend that such a policy orientation can authentically be grounded, and thereby Islamically legitimated, in the *maqāṣid*.

Moving from health policy to the clinical bedside, Chapter 5 details how leading Muslim thinkers such as Dr. Omar Kasule and Prof. Tariq Ramadan draw upon the *maqāṣid al-Sharīcah* to furnish deliberative models for clinical medical ethics. These and other scholars have different understandings of the human interests represented within the *maqāṣid* and hence take different paths to extend upon classical theories. Categorizing these approaches into three broad ones—field-specific redefinition, conceptual extension, and text-based postulation—I discuss the medical ethics deliberative model that emerges from each approach. Chapter 6 features a test case, a brain-dead pregnant Muslim woman, and analyzes the merits and pitfalls of each *maqāṣid*-based medical ethics model. Specifically, I delineate what each model suggests is the end goal for healthcare and

the accompanying moral responsibilities of the patient's Muslim surrogate decision-makers. I also compare these solutions with the extant Islamic rulings to evaluate the alignment between fiqh-based and *maqāṣid*-based solutions.

Chapter 7 brings historical debates regarding whether the preservation of life or the preservation of religion is the highest-order objective of Islamic law into conversation with discourse regarding the importance of spiritual care provision and the role of religion in contemporary healthcare. For *maqāṣid*-based frameworks to furnish a healthcare philosophy and be used in health policy analysis and medical ethics deliberation, clarity regarding which takes priority is necessary. This chapter weighs in on these considerations.

The final chapter, Chapter 8, covers the promises and perils of the *maqāṣid* and biomedicine discourse. I describe phases of *maqāṣid* research, outline shortcomings in present discourse, and offer provisional strategies to overcome the observed shortcomings.

By reading this book, the reader will undertake a journey that examines how extant theories of the *maqāṣid al-Sharīʿah* might furnish conceptions of health, bioethical frameworks, and health policy agendas, and, in so doing, bridge the Islamic tradition with contemporary biomedicine.

Who is This Book For?

If you have reached this far, I would argue that this book is for you. Keep reading! As gleaned from the discussion above, this book will prove valuable to many different audiences. Most immediately, it represents an essential resource for academicians and intellectuals researching the applicability of *maqāṣid al-Sharīʿah* to contemporary society as well as those working at the interface of Islam and biomedicine. As the book emerges from a research project seeking to bridge the worlds of Islamic law and contemporary biomedicine, it contains new knowledge relevant to this intersection. At the same time,

practitioners should also find this book valuable. In particular, those working in the areas of health policy, bioethics, and healthcare system design, where Muslim perspectives are welcome. This book provides insights into the design of Islamically-oriented health policies, health-zcare systems, and medical ethics in both Muslim majority and Muslim minority contexts. In addition to these principal audiences, the book will be of interest to practicing Islamic jurists and Muslim clinicians as it provides a critical commentary on the current state of contemporary healthcare and points out limitations within *maqāṣid al-Sharīᶜah* frameworks.

Finally, the book was written with a general audience in mind. Readers interested in contemporary Islamic thought, critiques of the biomedical model, and the interplay between religion and modernity will find this book to contain worthy analyses.

1

BIOMEDICINE AND CONTEMPORARY HEALTHCARE: DELINEATING THE PROBLEM-SPACE AND CONTEXT

Before explaining the theoretical bases and leading frameworks for the *maqāṣid al-Sharīʿah*, I should offer a few remarks on the 'field' these will be used to address: biomedicine. Though the term appears quite straightforward in meaning, biomedicine is much more than an area of study at the intersection of biology and medicine; rather, it is more akin to a Kuhnian paradigm.[1] Ubiquitous today, the term biomedicine was birthed in early twentieth-century Europe and the United States to describe medical and scientific research related to radioactive materials.[2] The term has greatly expanded beyond these humble origins to now represent "the umbrella theoretical framework for most health science and health technology work done in academic and government settings."[3]

The biomedical framework delivers therapies based on scientific experimentation and grounds itself in the physical sciences of biochemistry, physiology, and pathology.[4] As such, the term biomedicine is oft-used as shorthand to distinguish 'Western'[5] healthcare delivery models[6] from healthcare based on folk remedies, spiritual cures, or intuition. In what follows, I provide an overview of what biomedicine signifies and how it relates to contemporary healthcare systems.

Biomedicine and Society

In her essay on the "bio" in biomedicine, anthropologist Muna Ali rightly points out that many Muslim thinkers and Islamic scholars fail to appreciate biomedicine's epistemological and ontological commitments.[7] As a result, these commentators overlook how the

emergence and framing of questions of health policy and practice result from conceptions of the human linked to particular ontological and epistemic schema, and that these conceptions, in turn, fuel expectations of the services clinicians provide as well as the manner in which they provide them. In bioethical discourses, this neglect contributes to Muslim scholars incompletely analyzing the problem-space and, as a result, generating partial solutions to the challenges confronting patients, clinicians, and policymakers. Addressing contemporary healthcare comprehensively requires a more complete understanding of biomedicine.

Broadly speaking, biomedicine signifies a theoretical framework together with a body of multidisciplinary knowledge that is used to identify and address human maladies.[8] Upon reviewing the history and philosophy of biomedicine, social epidemiologist Nancy Krieger offers up three hallmark features of the biomedical approach. First, diseases are tied to biological, chemical, and physical phenomena. Second, biomedicine prioritizes knowledge garnered through experimentation, whether that be in the laboratory or in clinical settings. Hence, translational research represents the ideal flow of biomedical research where findings from laboratory research setup controlled experiments, for example, clinical trials in patients, and trial results are mobilized to support implementation of therapeutic regimens in clinics and hospitals.[9] Third, biomedicine is committed, philosophically and methodologically, to reductionism. In other words, the human being is understood through examining its subsidiary parts and, in concert, the phenomenon of human illness is best explained by disorder, malformation, maladaptation, dysfunction, or some other structural or functional issue occurring within these constituent parts.[10] These features build upon each other to create a cohesive theoretical framework that, when applied, delivers a distinctive body of knowledge. A naturalistic account of disease requires methodological naturalism be employed in research, and, in turn, lends explanatory power to reductionism. Krieger's description

highlights the philosophical and methodological commitments of biomedicine while making visible its incommensurability with other conceptions of biology and health.

It follows that, in Aristotelian terms, biomedicine (and healthcare systems operating out of this model) largely focuses on material and efficient causes of the human condition. It eschews final causes and its relevance to deciphering formal causes is debatable.[11] Accordingly, the etiology of disease, as well as the grounds for cure, is to be found in the body; the body's anatomical structures, biochemical functions, and physiological processes contain truths about human disease and cure. Primacy is given to the 'hard' sciences of biology and chemistry as materialism is biomedicine's principal grounds for knowledge. Technology is used to examine and probe the human body so that it reveals its secrets, and biodata in the form of chemical markers, physiological thresholds, and others is sought to ascertain the presence of disease, its status/progression, and its resolution. Biomedicine insists upon causal chains that specify pathogenesis in a language of structural flaws and malfunctioning bodily mechanisms. Indeed, when compared to other healthcare systems such as the Ayurvedic,[12] biomedicine is unique in its overriding focus on objectifying, classifying, and quantifying the human body according to disciplinarily constrained norms, deviations from which mark supposed disease.[13]

As Ali notes, the biomedical notion of knowledge and its accompanying technologically driven practices are entangled with enlightenment ideas about nature and what is knowable.[14] Biomedicine's concept of nature is thus rooted in a materialistic and mechanistic worldview, notes the renowned physician and anthropologist Arthur Kleinman. It also holds "the psychological, social and moral… as superficial layers of epiphenomenal cover that disguise the bedrock of truth, the ultimate natural substance in pathology and therapy, the real stuff: biology as an architectural structure and its chemical associates."[15]

The biomedical approach to human maladies is hegemonic; all other systems of assessing and treating maladies must submit to the epistemological framework of biomedicine or risk being dismissed as quackery. This dominant position results not only from the authentic explanatory power, and resulting therapeutic proficiency, of biomedical frameworks, but also from cultural power dynamics. For example, many traditional systems of identifying, assessing, and treating diseases were undermined or directly attacked by colonial governments. The power dynamics and cultural imperialism has continued long after the era of colonialism ended as biomedical education and practices continue to be exported from Western countries into low- and middle-income countries and supplant traditional and folk practices.[16] At the same time, economic factors also contribute to the growing dominance of biomedicine. Industries capitalize upon biomedical knowledge to commodify both health and illness states in offering biotechnology-driven enhancements and solutions. These marketable solutions capture the public's imagination to create a clamour for access. Research follows alongside as many pharmaceutical companies conduct clinical trials in non-Western nations, e.g. China, due to the lower costs associated with such. Hence the formation of biomedical knowledge and its application follow a West to East and Global South pattern.

Given this, biomedicine is intrinsically linked to healthcare delivery across the globe, and its epistemological and philosophical commitments have become embedded within contemporary medical practice. The physician's daily work of identifying, diagnosing, and treating patients is wedded to the naturalistic, reductionist, mechanistic understandings of the human being. Ideally, the clinician is to identify and diagnose human maladies by obtaining biological data and examining bodily structures. Only after interrogating the body in this way can the physician properly manage and treat the malady by selecting an appropriate biostatistically validated therapeutic. Understanding and addressing the more subjective aspects of

the patient's experience of illness is largely left to non-physicians such as psychologists, social workers, and spiritual counselors, with the exception of psychiatrists who do venture into subjective experiences. Yet, this specialty is also not without its inclination for eliciting data from the body and prescribing biochemical therapeutics as correctives. Importantly, meaning and individual/personal experiences are not the central focus of the clinical encounter; and, because it eschews teleology, "a moral purpose to the illness experience is a biomedical impossibility."[17]

Moving upwards, patient-level biomedical data is aggregated into larger population and societal-level data stores, which in turn are used to rate healthcare quality and rank how well countries perform in meeting the healthcare needs of their citizens. Aggregate data also sets up the boundaries of biological normativity; deviations from these norms furnish the grounds for the socio-cultural construction of disease states. Once the label of disease is applied to these conditions, pharmaceutical and biotechnological companies take up the cause to help develop treatments and cures for the maladies.

It is of no surprise that biomedically oriented healthcare delivery is practiced in an environment where market forces and industrial values are at play. Maladies such as organ failure and an inability to reproduce demand technological solutions and, once developed, these solutions necessitate payment. As a result, body parts, and health itself, is subtly commoditized. Managing biodata and finances requires a robust administrative infrastructure and, as a result, healthcare delivery is accompanied by a suffocating bureaucracy. This overpowered administrative structure reinforces the importance of efficiency and reliability under the banner of affording greater access to patients and advantaging healthcare equity. While these outcomes are laudable and just, these efforts are also part of the larger, more fiscally linked movement, focused on delivering value-based healthcare. For example, in the United States, one of the ways to measure the value of a physician's work, that is, their productivity, is

by assessing how many relative value units (RVUs) the clinician generates over the course of patient care. Each RVU represents the amount of dollars one can expect to receive for physician work, and resultantly the value of a physician employee is transformed into fiscal worth to the employer. To be sure, there is much more to value-based care than RVUs, and a physician's value is not only counted in dollars. However, this example illustrates the insidious ways in which commercialistic tendencies and industrial values shape contemporary healthcare. This inflection is not surprising given that biomedicine co-evolved with social and economic institutions in post-World War II Europe and the United States. And in this milieu the merits of healthcare provision were often viewed through the lens of the economic benefits of a healthy workforce.

Due to the way it is organized within society, biomedicine lends itself to becoming a tool for governments to exert biopower by shaping the social realities of their citizenry.[18] Indeed, biomedicine is nearly peerless in its motive force given how closely it aligns with the modern state's mechanisms of social control and general public legitimacy. The COVID-19 pandemic is an excellent example of this phenomenon. Public health agencies and legislators enacted controls on social life based on biomedical rationale, even though the biomedical data supporting such policies was initially scant, and the evidence remains contentious even today.[19] Indeed, Kleinman argues that biomedicine is industrialized society's leading institution for managing social reality. The predilection for (bio)medicalizing social problems such as alcoholism support this view.[20]

Biomedicalization

Biomedicalization describes "a process by which human problems come to be defined and treated as medical problems."[21] It can be considered a broad social phenomenon that may involve social groups as well as individuals, and may equally engage lay, professional, and

political discourses. The process of biomedicalization involves referring to a problem in terms of concepts, practices, and technologies that are endemic to biomedicine. When problems are framed in this way, biomedically oriented solutions often follow. For example, the use of illicit drugs repeatedly can be viewed in many ways, from a personal failure resulting from the loss of willpower, to a disease resulting from dysfunctional neuro-signaling attributable to chronic drug exposure. When biomedical explanations for a condition or behavior become dominant in society then biomedicine is also relied upon to generate solutions. Similarly, social practices that can be conceived of as having been biomedicalized are ones where the practice is justified in terms of health or illness considerations. In other words, medical rationales and meanings become primary supports for the practice.[22]

As biomedicine has taken hold so has biomedicalization. Discourses related to gun control, drug use, and domestic violence are replete with biomedical explanations for these behaviors, as well as biomedical solutions addressing their harms. Recent trends in healthcare research further motivate biomedicalization. For example, increased attention to evaluating how the social determinants of health (e.g., access to quality food and education), influence disease outcomes provides the foundations needed for public health agencies to contend that health must be prioritized in social policy-making.[23] This privileging fixes society's gaze solely upon bodily conditions and their material causes, and risks obfuscating other contributors to societal issues.

To be sure, biomedicine has become globally dominant in defining health and disease, in evaluating their presence or absence, and in providing remedies to social ills through professional channels. The globalization of biomedicine is promulgated through formal medical education systems that are exported from, or mimic, Western medical academies. The curricula taught by these academies produce physicians steeped in biomedicine's technologies, practices, ways of thinking and knowing, and understandings of the human being.

Even though the Western bioethical perspective that these physicians are trained to universally apply may be incommensurable or otherwise at odds with the value systems of the communities they serve. This bioethics is narrowly constrained to focus almost entirely on using mid-level moral principles to solve ethical puzzles at the bedside; it deems the analysis of social structures that lead to ethical challenges at the bedside to be out-of-scope. As sociologist Raymond De Vries puts it, clinical ethicists have become tools within a proverbial bioethical emergency room focused only on triaging issues and neglecting, or being otherwise constrained from attending to, the root causes of these problems.[24] Islamic scholars weighing in on bioethical issues often get caught up in the same trap, focusing on bedside issues without considering the social structures that create the challenge itself.

In light of the foregoing overview, biomedicine is best conceived of as the domain of certain types of knowledge along with sets of aligned clinical practices that are involved in the enterprise of producing societal health. This definition of biomedicine, along with its philosophical and epistemological commitments related to naturalism and reductionism, should be accounted for when embarking on an Islamic critique of contemporary healthcare.

Healthcare Systems

Just as the paradigm of 'biomedicine' is narrowly conceived of as 'medical practice' by many Muslim thinkers and Islamic scholars, the concept of 'healthcare' is commonly reduced to "allopathic medical systems."[25] This flattening is understandable because biomedicine is closely tied to the allopathic medicine; however, that system is not the only one operating in society. Rather, multiple healthcare systems exist in any given society; at times, they compete with one another, but more often than not, they work within their own, to borrow a term from Gould, nonoverlapping magisteria.[26]

A healthcare system represents socially organized responses to illness. Existing outside of individuals and discrete institutions, healthcare systems are culturally informed social realities that contain frameworks that legitimate illness, construct the illness experience, and define social roles for both patients and healers.[27] This broad definition accords with the idea that an individual's clinical reality is culturally constructed: people seek to understand their maladies. When they find explanations for their illness experiences that are particularly apt and powerful, they pursue therapeutics that align with those explanations.

In any given society, healthcare systems organize around these explanatory frameworks and operate in, at a maximum, three social sectors: the (i) popular, (ii) folk, and (iii) professional. The popular sector involves one's family, social network, and community, and includes the advice or services obtained from these sources with respect to identifying the malady and its cure. For example, this domain includes the over-the-counter remedies one may take for a cold upon the advice of relatives, as well as the chicken soup with purported healing powers made by one's grandmother. The professional sector comprises healthcare practitioners that society has licensed and their services. The folk sector lies in between these two. It involves religious healers and their prescriptions, social support groups, 'alternative' healers, and the like. The dividing line between folk and professional healers varies from society to society. In Mainland China, for example, practitioners of traditional or 'folk' medicine are authorized by the state to provide healthcare services and, in that context, are part of the professional sector insomuch as practitioners of allopathic medicine are. Both explanatory models—the biomedical and the traditional Chinese—operate in that society within the popular and professional sectors. By contrast, within the United States, for example, Chinese healers have a constrained scope of practice and are thus considered alternative or complementary medicine practitioners and lumped within the folk domain.

As individuals seek to move from states of illness to wellness, they variably engage with the popular, folk, and professional sectors of specific healthcare systems. Those systems, in turn, are undergirded by a specific explanatory system that labels diseases/illnesses and delineates means of healing/cure. Individuals may amalgamate different systems together during their healing journey, creating an integrative healthcare system of sorts, or they may differentially participate in one or another system based on their self-understanding of their malady, the level of access they have to one or another system, their trust in different healthcare agents, and their belief in one or another explanator.[28]

In most contemporary societies, biomedicine's explanatory model operates through practices within each of the popular, folk, and professional domains. Biomedical understandings of disease inform the drugs found on the shelf of the local pharmacy, as well as practices within the professionalized allopathic healthcare system. Even alternative healers within the folk domain, such as massage therapists or naturopathic healers, have to acknowledge that biomedical understandings underpin how their patients understand their illnesses. While biomedical healthcare systems are perhaps the most familiar and common globally, especially in the West/Western-dominant cultures, other systems always exist in any given society, and these also can have popular, folk, and professional dimensions. Importantly, not all healthcare systems operate in all three sectors.

Important examples of powerful non-biomedical systems that attend to human maladies are faith-based healing systems. Religion contributes to a patient's cultural construction of clinical reality by shaping the way individuals perceive, label, and evaluate their illnesses and by guiding individuals' choices regarding when, how, and from what domains of the healthcare system to seek help.[29] An individual may attribute their illness to a religious failing and, in turn, may seek the advice of a devout friend about how to combat that ailment, thus engaging the popular sector. Alternatively, they may seek

medicaments based on religious texts which lie in the folk domain or instead turn to a trained religious counselor who represents the professional sector. Self-understandings, religious values, and social norms influence how individuals engage with religious and other healthcare systems.

Overall, the vast majority of social responses to illness within a given society occur within the popular domain. According to some estimates, between 70–90 percent of individual responses to self-perceived illness are addressed through regimens available in this domain upon the advice of family members, friends, and community members.[30] In aggregate and at the societal level, the professional sector, on the other hand, contributes a relatively minor amount to moving individuals from states of illness to wellness. Moreover, allopathic clinicians are professional representatives of but one of the many healthcare systems that individuals may turn to and, as such, play a smaller role than commonly imagined within any given society's aggregate response to illness.

As Muslim thinkers engage in analyses of contemporary healthcare in society, this broader understanding of, and social structuring within, healthcare systems is necessary. The existence of multiple healthcare systems operating within any given society also merits consideration.

Biomedicine and Healthcare: The Context for Engagement with the *Maqāṣid al-Sharīah*

The preceding discussion sets up our engagement with the *maqāṣid*. Addressing biomedicine from an Islamic lens requires deep knowledge of its various elements. The philosophical, epistemological, and ontological dimensions of biomedicine must be acknowledged and assessed for compatibility with Islamic schemas. The social structures that undergird healthcare must be examined for alignment with Islamic moral frameworks. The understanding of health, disease,

illness, and cure, as well as the physician and patient roles in biomedical practice, must be considered in light of Islamic understandings sourced in scripture. And the social structuring of healthcare systems across professional, folk, and popular sectors should be evaluated in light of Islamic ideals. In order to begin these tasks, the next chapter begins with an outline of two dominant frameworks for the *maqāṣid al-Sharīᶜah*.

Having delineated biomedicine and its aligned healthcare system as the problem-space, we now turn to the core task at hand bringing biomedicine into dialogue with the *maqāṣid al-Sharīᶜah.* Given that the *maqāṣid* are deliberative tools of the Islamic ethico-legal tradition, the main part of this book examines the utility of the *maqāṣid* for two practical purposes: generating health policy and deliberating over ethical issues in clinical care (Chapters 4, 5, and 6). While the book will dive into theoretical considerations related to conceptions of health (Chapter 3) and giving primacy to the preservation of religion or to the preservation of life in healthcare (Chapter 7), more upstream analyses of biomedicine's ontological, philosophical, and epistemological commitments are the remit of a future project. Similarly, assessing how non-allopathic healthcare systems cohere with Islamic visions of health, healing, and social order requires a dedicated project and is outside of the scope of this book. Nonetheless the preceding discussion of biomedicine and healthcare systems provides the necessary foundation for such research.

2

AN OVERVIEW OF MAQĀṢID AL-SHARĪAH FRAMEWORKS: DESCRIBING THE TOOLS

The Widespread Interest in the *Maqāṣid al-Sharīah*

At present, the *maqāṣid* are prominently featured in multiple vibrant global discourses. As noted in the introduction, the topic arises routinely in Muslim media, within Islamic studies journals and conferences, and in policy circles. The *maqāṣid al-Sharīʿah* capture the imagination of Muslim thinkers for many reasons.

From a historical perspective, this current interest has roots in social and political conflict and division. The aftermath of colonialism and subsequent rise of the modern nation-state sowed the seeds for intellectual stagnation within traditional institutions of Islamic learning. Islamic seminarians were left ill-equipped to address the new social orders stirred by the many -isms of the post-colonial and contemporary period: secularism, political authoritarianism, pluralism, globalism, and scientism, to name a few.

Against this backdrop, multiple revivalist projects set about reforming Islamic law and developing new models for ethico-legal reasoning capable of meeting the demands of a global and plural world. For quite a few scholars, the *maqāṣid al-Sharīʿah* present tools and frameworks for such rejuvenation.

This genre of ethico-legal reflection is attractive and promising to scholars seeking to modernize Islamic thought because it is believed to offer a corrective for Islamic rulings (fiqh) that are seen as formulaic and inflexible. *Maqāṣid al-Sharīʿah* frameworks are also held, at a minimum to supplement, and maximally to supplant, Islamic moral theology[1] (the hermeneutical science that undergirds fiqh).[2] It is argued that since the higher objectives of the Lawgiver are more

closely connected to the moral vision of Islam than a singular scriptural statement or a solitary ruling based on a collection of such evidences, possessing knowledge of these higher objectives is more central to law-making than scriptural hermeneutics.[3] Furthermore, ethico-legal reasoning based on the *maqāṣid* is believed to better incorporate data from the social and natural sciences than traditional *uṣūl*-based methods of generating fiqh, that is, rules, policies, and laws. Reformers thus champion the development of *maqāṣid*-based frameworks to allow the inherited Islamic ethico-legal canon to extend its reach to modern contexts. Consequently, interest in the *maqāṣid al-Sharīʿah* emerges as part of a broader intellectual project to reform Islamic law and ethics.

In addition to being of interest to Islamic scholars and thinkers, the *maqāṣid* are of use to policymakers and experts engaging in transnational discourses and civil dialogue. Within these spheres, the fact that the higher objectives of Islamic law incorporate human interests that are rationally accessible and have analogs within diverse ethical systems helps to facilitate conversation across cultures and value systems. In terms of familiarity or recognition, for example, one of the classical higher objectives of Islamic law is preserving wealth (*ḥifẓ al-māl*). This goal resembles the ethical values of fiscal responsibility and stewardship in various non-Islamic moral frameworks. Hence, the *maqāṣid*, without scriptural supports, can be used alongside principles emerging from different value systems for constructive ethical and policy dialogue. Beyond familiarity or overlap, *maqāṣid*-based models are attractive to professionals, academics, and researchers who are *not* specialists in Islamic law and are more readily acceptable to non-Muslim/secular stakeholders because they directly appeal to human rationality. Said another way, because the human interests and values represented by the *maqāṣid* have a rational foundation (even though they are scripturally derived), Muslim stakeholders can easily understand and make use of *maqāṣid*-based ethical and policy tools in their secular and sacred projects. In so doing, they can label

their work as Islamically oriented and aligned with their Muslim identity.

Defining the *Maqāṣid al-Sharīah*

Despite all of the *maqāṣid* talk, the term remains a source of confusion because of its imprecise usage and intrinsic ambiguity. Lexically, *maqāṣid* is the plural of the Arabic word *maqṣad*, which conveys various meanings, including purpose, goal, objective, and intent. The term *Sharīᶜah* refers to Islamic law derived from the scriptural source texts of the Qur'an and Sunnah.[4] In English, the *maqāṣid al-Sharīᶜah* are most commonly translated as the purposes/goals/intents/objectives of Islamic law. And they are typically specified as the overarching or higher-order objectives of the entire legal corpus. Yet, despite these definitions, it remains unclear what the precise objectives are and what they pertain to. Are they the worldly or the afterlife outcomes sought by the adoption of Islamic law? Or are they the intents of the Lawgiver in legislating? Or are they the human interests that the law serves? Or are they the specific legal causes for a group of related rulings? Adding to this lack of clarity for the non-specialist, the term can also denote a particular genre of Islamic ethico-legal writing that pertains to understanding, explicating, and developing Islamic jurisprudential and ethical frameworks based on the *maqāṣid*.

To start building up an understanding of the term, it is essential to recognize that because Islam is a scriptural tradition, Islamic theologians and jurists have always been interested in the reasons behind commandments and prohibitions in the Qur'an and voiced by the Prophet Muhammad. Indeed, discerning why God or the Prophet issued a certain ruling yields insights into the human–God relationship, including what values are important to the Lawgiver and His concerns for humankind. Identifying the rationale behind a scriptural judgment also enables Islamic jurists to use analogical reasoning for issuing rulings about matters that are not directly attended

to by scripture. Although theologians and jurists debated whether or not God legislated purposively and, if so, to what extent humans could comprehend such intents, ultimately, Islamic legal theories have been built upon the premise that God legislates through the Qur'an or the Prophet with purposes that human rationality can access with a reasonable degree of certainty.[5] Accordingly, Islamic theories of law utilize various formal methods to derive moral law from limited scriptural source texts. An important corollary to this theological doctrine is that the overall purpose of Islamic law is to serve human interests (in this world and the hereafter) by deflecting harms and bringing about benefit.[6]

Delving deeper into legal terminology, the term *maqāṣid* is related to several concepts and technical devices. Depending on the scholar and the literary genre, these terms may be used interchangeably for rhetorical purposes. The related constructs are *ḥikmah*, *ᶜillah*, and *maṣlaḥah*. A detailed explanation of what these terms mean and how they are used within Islamic law is beyond the scope of this book, yet describing how these terms relate to the *maqāṣid* will assist the reader in understanding the frameworks and theories presented in subsequent chapters.

As mentioned above, the *maqāṣid al-Sharīᶜah* refer to the overall "purpose[s] or goal[s]" of Islamic law and "the underlying reasons which the Lawgiver has placed within each of its rulings."[7] When considering the purpose of the legislation as it relates to the outcome sought, the term *ḥikmah* is, somewhat confusingly, used synonymously with a specific *maqṣad*.[8] However, the more widely accepted usage of *ḥikmah* is for discussing the Divine purpose behind a given ruling rather than just the ends sought by it. Furthermore, jurists usually use the term *ḥikmah* when discussing God's intents, and *maqāṣid* when discussing matters of law and what it accomplishes; this underscores an epistemic gap between human understandings of God's legislative purpose and His true purpose.[9]

The notion of servicing human interests brings the *maqāṣid* into connection with the construct of *maṣlaḥah*. The polymath jurist-theologian Abū Ḥāmid al-Ghazālī (d. 505/1111) is commonly credited with being the first scholar to comprehensively map out and connect the two terms. He states "what we mean by interests (*maṣalih*) are those interests that conform specifically to the objectives of Islamic law (*maqāṣid*)."[10] Although one must bear in mind that while *maṣalih* (plural form of *maṣlaḥah*) and *maqāṣid* are "parallel concepts and basically look at the same values,"[11] *maṣlaḥah* as a legal device can be classified into several subtypes, each of which carries a different level of validity in legal argument.[12] Therefore, using the terms interchangeably is fraught with complications that non-specialists should avoid.

In Islamic legal terminology, the term *ᶜilal* (plural of *ᶜillah*) is also closely related to *maqāṣid*. The term *ᶜillah* is used in three ways, to indicate: (i) "the benefit or harm resulting from an action; (ii) the achievement of benefit or the prevention of harm resulting from the legislation of a given ruling; and (iii) the observable, identifiable condition or situation based on which a given ruling is legislated for human beings' benefit."[13] Among these usages, one can observe that the terms *ḥikmah* and *maṣlaḥah* map onto the first two connotations of *ᶜillah*, while the term *maqāṣid* can be used for the third.[14] When undertaking Islamic analogical legal reasoning, *qiyās*, the term *ᶜillah* refers to the observable, identifiable, triggering condition(s), that is, *ratio legis*, that are the basis of the particular legal ruling.[15] This condition, which was the rationale for the original judgment, might allow for extending the ruling to the new circumstance if found in a new context. The term *ᶜillah* is best used for this technical purpose to avoid confusion. Finally, the term *maqāṣid al-Sharīᶜah* conventionally refers to the overall rationale or comprehensive and general objectives of the law (*al-maqāṣid al-ᶜāmmah*) and not the singular and particular *ᶜillah* behind a rule; hence "*ᶜillah* is very close to *maqāṣid*" in meaning but not the same.[16]

An example that illustrates the conventional distinctions in terminology involves the ruling that one can shorten prayers on a journey.[17] Here the ʿ*illah* is being on a journey, the *ḥikmah* is the removal of hardship, the *maṣlaḥah* is the facilitation of worship, and the *maqṣad* is the preservation of religion. Therefore, the ʿ*illah*, which is the cause and trigger for the ruling, is attached to the moral agent but stands somewhat apart from the wisdom of the Lawgiver. The wisdom, in turn, is closely related to the human benefit to be secured. On the other hand, the higher objective is further upstream from the particular ruling and is general in nature (see Table 2.1).

Table 2.1: *Relationships between Objectives, Wisdoms and Human Interests*

TERM	CONNOTATION	DEFINITION WITH RESPECT TO ISLAMIC LAW	AS SPECIFIED IN THE PERMISSION TO SHORTEN PRAYERS DURING TRAVEL
maqṣad (pl. *maqāṣid*)	Goal, objective, purpose	The overarching Divine purpose undergirding a ruling	The preservation of religion
ḥikmah (pl. *ḥikam*)	Wisdom, intent	The wisdom contained within a Divine command	Removal of hardship in human life
ʿillah (pl. *ʿilal*)	Rationale, reason	The specific trigger condition or rationale that is the cause for a ruling	Being on a journey
maṣlaḥah (pl. *maṣālih*)	Benefit, interest	The human benefit that accrues as a result of, or is the desired outcome, of a ruling.	Facilitation of worship

How are the *Maqāṣid* Identified?

While scholars may have different views on what the higher objectives of Islamic law are, they all agree that they are primarily sourced in the Qur'an. Imam Abū Isḥāq al-Shāṭibī (d. 790/1388), a fourteenth-century Sunni legal theorist and Maliki jurist widely considered to have developed the first comprehensive *maqāṣid al-Sharīʿah* theory, relied on inductive methods to discern the objectives of Islamic law. He states that the *maqāṣid* are the "fundamentals of religion, basic rules of the revealed law, and universals of belief."[18] By alluding to them in this way, he asserted that all Islamic laws must be built upon the foundations provided by the *maqāṣid*. Lest these foundations are shaky, al-Shāṭibī had to prove that the *maqāṣid* can be gleaned from the Qur'an with epistemic certainty (*qaṭ'ī*).

His genius lay in demonstrating that a comprehensive, inductive reading of the scriptural sources of Islam, the Qur'an and Sunnah, results in epistemic certainty. The inductive method is central to al-Shāṭibī's theory, and by extension to all other *maqāṣid* models, for "the universals of Islamic Law are not based on a single piece of evidence, but on many such pieces which, when taken together, convey a single message which is thereby invested with complete certitude."[19] Al-Shāṭibī notes that his theorization involved a reading of "'all inclusive references rather than limiting [himself] to isolated particulars, demonstrating the textual and rational foundations of [Islamic law] to the extent that (he) was enabled to elucidate'" the *maqāṣid*.[20] Through the use of induction, he arrives at three conclusions: (i) Islamic law serves human interests; (ii) there are five specific essential higher objectives of Islamic law (to be discussed below); and (iii) these higher objectives can be grouped into three categories (essential, necessary, and enhancing).

While induction is the principal method for discovering the *maqāṣid*, other methods can be used. In the concluding section of the Book on *Maqāṣid* within his tome, *al-Muwafaqqāt*, al-Shāṭibī states

that the secondary objectives of the Lawgiver are discerned in one of four ways: (i) by looking at specific, explicit, and univocal commands and prohibitions wherein the Qur'anic text notes the purpose of the ruling; (ii) by utilizing established conventions of *uṣūl al-fiqh* to uncover the rationale (*ᶜillah*) underlying commands and prohibitions; (iii) by inferring secondary objectives that cohere with the explicitly noted primary objectives within scripture; and (iv) by using human reason. The first supplemental method involves linguistic analysis, the second legal hermeneutics, and the third inferential analysis. Notably, these three methods require the scholar to examine scripture. The fourth method goes beyond scripture in using human reason to glean insights from society and the natural world independently. This latter method is exceedingly controversial as it can substantiate a human interest for which no scriptural evidence exists.

For al-Shāṭibī, a Mālikī legal theorist, the 'reason only' method equates to using the legal, methodological device of *maṣlaḥah mursalah*.[21] On the other hand, the pre-eminent classical Shāfiᶜī jurist-theologian al-Juwaynī validated *istiḍlāl*, a reasoning technique used in the Shāfiᶜī school of law, as a means to 'discover' *maqāṣid*. Other theorists referred to this final means as simply using human intellect (*ᶜaql*).[22] The argument for using reason to discern *maqāṣid* is based on the premise that, since human benefits undergird the Lawgiver's injunctions, these benefits must be discernable to human reason, otherwise human beings would be unable to express gratitude to the Lawgiver or, worse yet, they would not be able to recognize the existence of a graceful Lawgiver. Accordingly, human reason must have epistemic authority to identify the *maqāṣid*. Hence, provided that scripture-based values are not violated, new objectives for Islamic law can be set simply by analyzing the benefits and harms of a certain action, rule, or policy. In al-Shāṭibī's theory, these secondary objectives are deemed valid intentions of the Lawgiver so long as they strengthen, reinforce, and support the primary (inductively arrived at) essential objectives.[23]

Viewed as a whole, proceeding from the first to the fourth method involves a greater level of theorization and entails a greater role for human reason. The first method remains close to the text. The second subsumes *uṣūl al-fiqh* rules for *ta'līl*; the third uses inference to discover a secondary objective; and the fourth utilizes human reasoning about benefits and harms to posit objectives of the Lawgiver. The operating space given to reason to 'go beyond' scripture is a critical aspect of *maqāṣid*-based theories; for it is the basis to the claim that *maqāṣid* frameworks readily adapt to changing societal norms and contexts. For al-Shāṭibī, these four methods come into play when discovering specific objectives underlying scriptural injunctions. They are always operating at a 'lower' level than induction, for induction is the only means by which the overarching higher objectives were discerned. As will be seen in subsequent chapters, other theorists do not constrain their theoretical frameworks the same way. Rather, for them, even the essential objectives of Islamic law can be adduced by reason.

Maqāṣid theorists after al-Shāṭibī mostly affirmed his methods. Some, however, add new ways to discern objectives, re-arrange his schema, and give more or less epistemic authority to reason.[24] For example, the contemporary theorist Jamal al-Din ᶜAtiyah (Gamal Eldin Attia)[25] states, "there is no conflict between a basic reliance on the methods outlined by al-Shāṭibī for arriving at *maqāṣid al-Sharīᶜah*, and the addition of supplementary methods in the event that the existing methods prove insufficient."[26] According to him, new *maqāṣid* are valid only when: (i) there is no definitive scriptural source that confirms or negates the *maqṣad*; (ii) the proposed *maqṣad* does not conflict with another *maqṣad* derived from scripture; (iii) the *maqṣad* emerges from, or at a minimum is informed by, reliably transmitted scriptural texts with self-evident meanings; and (iv) the proposed *maqṣad* is consistent across time, person, place, and context. He further notes that when there is conflict between a proposed *maqṣad*

and scriptural sources, or *maqāṣid* derived therefrom, established hermetical rules must be used to resolve the apparent tension.[27]

It bears mentioning that there is a certain level of ambiguity in Attia's rubric: if one uses reason to discern human interests and elevate them to the level of a higher objective of Islamic law, then such usage is independent of, or at best supplemental to, scripture. Accordingly, the criteria set forth to legitimate such *maqāṣid* cannot use scripture as a validating authority. In my view, ambiguity concerning the use of reason independently emerges from Attia's strategic need to obtain buy-in from traditional legists who desire to remain close to the texts and within the bounds of inherited *uṣūl* paradigms; giving reason full epistemic authority would be viewed with suspicion. Another reason may be that theoreticians like Attia focus on setting out broad parameters for theory-building: they expect to make further refinements after their models are tested and applied in society.

The rest of this book will primarily draw upon the *maqāṣid al-Sharīʿah* frameworks of Imam al-Shāṭibī and Prof. Attia and, in so doing, bring a classical and a contemporary model into conversation. Consequently, the way these models classify the higher objectives, and the higher objectives at the core of each model, are presented next.

Al-Shāṭibī's Theory: Categorizing the *Maqāṣid* and Identifying the Essential Ones

Imam al-Shāṭibī divides the *maqāṣid* into three categories of descending import: *ḍarūrī*, *ḥājī*, and *taḥsīnī*. *Ḍarūrī* (the 'essential *maqāṣid*') "seek to establish interests of the *dīn* [literally 'religion,' but connotes the hereafter in this usage], and the *dunya* [this world]… their absence leads to corruption and trials as well as loss of life," and "loss of success and blessings" in the hereafter.[28] The *ḥājī* (the 'necessary *maqāṣid*') are those needed to attain facility and remove obstacles to flourishing; for

their absence creates difficulty and hardship in human lives. The *taḥsīnī* (the 'enhancing objectives') involve acquiring the "good things" and avoiding the "deceptive" things in terms of social etiquette, personal character, and manners.[29]

The relationship between these categories is that the *ḥājī* supplement the *ḍarūrī*, and the *taḥsīnī* complement the *ḥājī*. Furthermore, when securing the objectives, a hierarchal order must be maintained such that while securing the *ḥājī* the *ḍarūrī* are not compromised because the *ḍarūrī* are the foundation for the *ḥājī* and *taḥsīnī*. For example, without preserving life (an essential objective in his model), there is no basis for teaching about good character (an enhancing objective in his model). Correspondingly "if the suspension of the *ḍarūrī* is assumed the other two will stand suspended in absolute terms."[30]

Imam al-Shāṭibī acknowledges that the *maqāṣid* may be categorized in other ways: in terms of scope—general (*ʿāmmah*), particular (*khāṣṣah*), or partial (*juz'ī*)—or in terms of certainty definitive (*qaṭ'ī*) or speculative (*ẓannī*). While these other classifications are used to explain the inner workings of his theory, the tripartite division of essential, necessary, and enhancing is a hallmark of his model. He conclusively demonstrated that this division is part of an Islamic moral vision. Hence, nearly all other theorists adopt this classification schema for the higher objectives of Islamic law.

His inductive reading of scripture yielded al-Shāṭibī with five *ḍarūrī* (essential *maqāṣid*). The pentuplet of overarching human interests served by Islamic law are: religion (*dīn*), human life (*nafs*), progeny (*naṣl*), material wealth (*māl*), and intellect (*ʿaql*). His method for discerning these involved closely canvassing scripture by looking at the commandments contained within Qur'anic verses revealed in Makkah, which according to him, contain the universal values of the Law, and then examining those revealed in Madinah, which describe particular human interests and their dimensions. He next proceeded to analyze the commandments and laws contained within the

Prophetic Sunnah to refine the framework because, according to him, these texts explain the values and interests found in Qur'an.[31]

To test his understanding of the core human interests, he scrutinized extant Islamic law. The four domains of Islamic law are: *ᶜibadāt* (worship), *muᶜamalāt* (human relations and transactions), *ᶜadāt* (human practices), and *jināyāt* (criminal law). Al-Shāṭibī hypothesized that one or another of the core human interests undergird all ordinances in each of these areas. He surmised that preserving religion is at the core of worship-related injunctions, while protecting life and human intellect is central to Islamic laws pertaining to human practices. Religious law related to human relations and transactions seeks to preserve material wealth and progeny. In contrast, criminal law focuses on protecting all five essential human interests through punitive and deterrent measures.[32]

Consequently, following al-Ghazālī's lead, al-Shāṭibī stated that the higher objectives of Islamic law entail the preservation (*ḥifẓ*) of these human interests. Preservation entails a dual responsibility: establishing the existence of the interest (*ibqā'*); and defending against its negation (*ᶜadam*).[33] The five essential *maqāṣid* are thus formulated as: the preservation of religion (*ḥifẓ al-dīn*), the preservation of human life (*ḥifẓ al-nafs*), the preservation of progeny (*ḥifẓ al-naṣl*), the preservation of material wealth (*ḥifẓ al-māl*), and the preservation of intellect (*ḥifẓ al-ᶜaql*).

Although these essential *maqāṣid* comprise an interdependent unit, al-Shāṭibī hints of a hierarchy, stating that if religion is not preserved then the "affairs of the next world cannot survive" because the purpose of worldly life is to procure salvation in the afterlife.[34] This hierarchical inflection does not, as might perhaps seem plausible, weaken the interdependence of the essential *maqāṣid*, but instead strengthens it. Indeed, while salvation in the afterlife is the supreme purpose of life, life itself is of the utmost importance and must be preserved: if human life is lost, there is no moral subject. Relatedly, he notes that individuals cannot maintain religious beliefs and values

without the capacity for reason. Similarly, if the capacity for progeny is universally lost, then the survival of human life writ large is at-risk. And without the preservation of material wealth, "[human] life cannot be maintained."[35] Consequently, preserving material wealth and the capacity for progeny is instrumental to the preservation of human life; and the preservation of intellect and of human life are both subordinate to the ultimate human interest: religion. After religion, al-Shāṭibī holds that preservation of life as the next most important *maqṣad*.[36] The order of priority among the other essentials (the preservation of progeny (*naṣl*), material wealth (*māl*), and intellect (*ʿaql*) is unclear, as al-Shāṭibī did not maintain a consistent ranking in his writings. However, some scholars contend that the initial order he presents is his preferred order.[37]

Moving from the essential to the necessary objectives, he does not specify the necessary objectives of Islamic law. Instead, he signals that removing difficulty and hardship is the spirit that animates necessary objectives. Islamic rulings cohere with these objectives, and include exemptions from worship during travel and illness. Such rules support the essential objective of preserving religion but are not essential because one may be able to pray while ill or traveling. The fact that the Qur'an provides the option of making up obligatory fasts after travel has been completed illustrates that removal of hardship is a valid objective of Islamic law.

Though removing hardship upon humankind may in and of itself be classified as a necessary objective within Islamic law, actions that align with this objective do not qualify as moral obligations because difficulties do not cancel out life. To be sure, he does not specify that removing difficulty is a necessary objective of Islamic law; rather, he indicates that the ethos of objectives that are classified as necessary within Islamic law accord with removing difficulty and facilitating the five essential interests of religion, life, progeny, material wealth, and intellect.

The ethos underlying the enhancing objectives is inculcating good character, facilitating moral formation, and beautifying human actions with refined etiquette. Again, al-Shāṭibī does not catalog such objectives; instead, he believes they must be determined based on context. In the aforementioned example of shortening prayer while on travel, one may contend that removing dirt from one's clothing before praying complements the act of worship and reflects the appropriate comportment when one is standing in front of God. Accordingly, an Islamic ruling that calls upon individuals to clean their clothes before praying can be deemed legitimate. Importantly, however, such a ruling would not be classified as a moral obligation since the preservation of religion is not at stake; rather, the act of cleansing would be deemed a supererogatory or recommended act.

In addition to envisioning a hierarchy, another way to describe the relationship between the *ḍarūrī*, *ḥājī*, and *taḥsīnī* objectives is by thinking of them as concentric circles. The *ḍārūrī* are the centermost circle and the *taḥsīnī* the outermost. In this way, the *taḥsīnī* and *ḥājī* protect the *ḍarūrī* objectives, and even if they are not accomplished, the *ḍarūrī* can be maintained.[38] Returning to the example of prayer, the preservation of religion through worship can be achieved even if one must pray with clothes that have minor amounts of impurities on them. It can also be accomplished without shortening the prayer during travel. Said more succinctly, neither clean clothes nor a shortened prayer is *essential* to the preservation of religion. Though not essential to the performance of prayer, shortening the prayer unburdens the traveling person, and wearing clean clothes assists with giving God His due. In this way, the essential objective of preserving religion is supported by actions that align with the necessary and enhancing objectives.

Attia's Theory: Classifying the Means to Achieve the *Maqāṣid*

Gamal Eldin Attia amends and builds upon al-Shāṭibī's framework in

several ways. For one, he asserts that the categories of *ḍarūrī*, *ḥājī*, and *taḥsīnī* (essential, necessary, and enhancing) pertain to the means (*wasā'il*) by which a particular objective is attained and not the *maqāṣid* themselves. Attia finds support for this view in the writings of a scholar who preceded al-Shāṭibī, al-ʿIzz al-Din ibn ʿAbd al-Salām, a master Shāfiʿī jurist-theologian.[39]

In this way when compared to al-Shāṭibī's framework, Attia's model shifts its focus away from the *human interests* to the *means* to secure said interest. For Attia, the higher objectives are singular goals that laws, policies, and actions can achieve. The minimal level of what is required within society to preserve a specific human interest is classified as the essential means for accomplishing it.

For example, like al-Shāṭibī, he considers the provision of food to be a core element of the *maqṣad* of preserving life. Attia holds that when one obtains enough food to stave off starvation, the essential threshold of what is demanded by the preservation of life has been met. The provision of a balanced diet accords with the necessary threshold, as it removes hardship and facilitates living; and elegant food presentation and refined table manners are enhancements to the preservation of life.[40] In this way, he mirrors al-Shāṭibī's designation that the necessary category relates to removing hardship from human life, and the enhancing category covers etiquettes.

While al-Shāṭibī's and Attia's models are distinct, they are brought into alignment if we look at the results produced. To better understand the distinctions and similarities, let us work through al-Shāṭibī's model to consider the provision of food as part of the *maqṣad* of preserving life. Concerning the essential objective of preserving life, one could argue that the Qur'anic command to eat of the pure and good things[41] reflects a necessary objective related to the preservation of life because eating food that is healthy supports living a life with less hardship. Similarly, the Prophetic directive to partake of what is nearer to one's plate covers an enhancing objective because it relates to etiquette. Yet, eating in and of itself must be treated as an action that

accords with the essential objective of protecting life for it staves off death. Accordingly, in al-Shāṭibī's framework, the preservation of human life demands that we must provide/procure/produce enough food so that humankind does not perish; we need to consider policies and laws that enable eating of the 'good and pure,' but policies that promote aesthetically pleasing food production, delivery, and consumption are optional.

Since Attia's model focuses on the means, it would consider those actions and policies that deliver enough food to stave off death as essential. Actions and policies that result in a person obtaining nutritionally balanced meals represent necessary means to preserve human life, and actions and policies that introduce etiquette are enhancing means to the preservation of life. Working through both models, the resulting state of the human being is nearly the same; the essential means in Attia's model deliver a barely surviving human being, and narrowly sufficing the essential objective results in the same state of the human in al-Shāṭibī's framework. Slight variances may appear in the quality-of-life that results from enacting necessary and enhancing means in Attia's model and securing the necessary and enhancing objectives in al-Shāṭibī's framework. Nonetheless, the models produce similar results despite different classification schemas and foci.

In addition to applying the labels of essential, necessary, and enhancing to means, Attia adds two other categories. The first, he places 'beneath' the essential and defines it as "that which falls short of essential (*mā dūn al-ḍarūrī*)";[42] and the second, he sets 'above' the enhancing, terming it "that which goes beyond mere enhancements (*mā warā' al-taḥsīnī*)."[43] These categories are important because they represent situations that demand remedy. In other words, a sub-essential means would not be sufficient for the preservation of life and thus requires Islamic legal remedies be enacted. Similarly, a means that goes beyond enhancing life is a harmful excess and thus demands ethico-legal intervention. Ultimately, Attia calls for greater study

into the means that fall into these two categories, as they are context-specific.

Having described the model, Attia turns to delineating means and explaining how they are placed within the aforementioned categories. The primary method is to search for a specific, explicit scriptural source that discusses the import of a particular means in terms of its benefits and harms. The greatest benefits accrued, or harms averted, belong to the essential category and the most minor to the enhancing means. In the absence of a clear scriptural text, one can categorize means by using analogical reasoning (*qiyās*) or seeking scholarly consensus (*ijmāʿ*). This methodology mirrors standard *uṣūl al-fiqh* practices.

However, when these methods do not provide answers, Attia proposes recourse to an "objective criterion," where the degree of benefits and harms are weighed by looking at societal data. Again, wherever significant benefit is obtained or harm is removed via a particular means that means belongs in the essential category, minor benefits accrued or harms averted place a means into the enhancing category, and the necessary means lie in between these two.[44] It is important to note that this weighing rubric enables Attia's theory to adapt to context by absorbing empirical, social scientific, and other data related to policies and methods for preserving human interests.

Attia identifies *maqāṣid* based on scriptural analysis as well as through independent reason. He describes twenty-four essential *maqāṣid* that pertain to four levels of human existence: (i) the individual, (ii) the family, (iii) the Muslim community (*ummah*), and (iv) humanity in general. Although he suggests five categories for means, Attia largely adheres to the *ḍarūrī*, *ḥājī*, and *taḥsīnī* classification schema. In what follows, I catalog the *maqāṣid* within each level but primarily focus on describing the amendments he makes at the individual level since these *maqāṣid* are the most comparable to al-Shāṭibī's *ḍarūrī* objectives. Furthermore, in detailing these *maqāṣid*,

I describe only the *ḍarūrī* means to secure them since these are immediately comparable to al-Shāṭibī's schema.

At the individual level, Attia's classification houses five *maqāṣid*: (i) the preservation of human life; (ii) considerations to protect the mind; (iii) the preservation of personal piety; (iv) the preservation of honor; and (v) the preservation of material wealth. While these *maqāṣid* resemble al-Shāṭibī's five essential objectives, Attia makes several modifications (see Table 2.2).

Table 2.2: *The Higher Objectives According to Imam al-Shāṭibī and Gamal Eldin Attia*

THE ESSENTIAL HIGHER OBJECTIVES AT THE LEVEL OF THE INDIVIDUAL					
Imam al-Shāṭibī	Preservation of Religion, i.e., Islam	Preservation of Human Life	Preservation of Reason	Preservation of Progeny	Preservation of Material Wealth
Gamal Eldin Attia	Preservation of Human Life	Considerations to protect the mind	Preservation of Personal Piety	Preservation of Honor	Preservation of Material Wealth

First, Attia elevates the preservation of human life to the foremost objective and expands upon what it requires.[45] He also reformulates the "preservation of intellect (ʿ*aql*)" to "consideration of the mind" and moves it to the second position. He expands consideration of the mind beyond the traditional view to now require developing intellectual capacities and utilizing the mind in "intellectual acts of worship."[46] Developing the mind also requires delivering scientific education, building academies, and otherwise nourishing and equipping the rational faculties of individuals. With respect to the means of preserving the mind, Attia concurs with the traditional view that it requires staying away from intoxicants, but also requires "eschewing behaviors that would impede the mind's functions or create mental confusion" and "avoiding media and cultural outlets which engage in

brainwashing operations."[47] The *maqṣad* also requires intellectual acts of worship, including reflecting on scripture, acquiring religious knowledge, and performing ritual meditations. Again, all of these actions are essential means by which the mind is preserved.

Attia refashions the preservation of religion into the preservation of personal piety and lowers its rank order to third, for "it is necessary first to preserve human life, which is the basis for all human action, then the mind, which is the basis for our being held accountable before God's law."[48] The essential means for preserving personal piety are establishing and strengthening religious doctrines, performing obligatory acts of worship and similar activities, and attending to moral formation.

Taking the lead from scholars such as al-Qarāfī, al-Ṭūfī, and others, Attia reintroduces the preservation of honor into the *maqāṣid*. He considers honor to refer to "anything related to human dignity" as well as one's reputation and "sanctity of one's private life."[49] This broad definition is more expansive than al-Shāṭibī's notion of preserving honor, which mainly relates to one's sexual reputation. The essential means to secure this interest includes preventing people from committing slander and making false accusations through penal injunctions.

Attia considers the preservation of material wealth to be the lowest priority objective at the individual level. He notes that the preservation of individual wealth has the social function of providing for one's livelihood and for populating and developing the earth—and thus serves the preservation of life. Attia refers to the Islamic laws of finance, contracts, ownership, and the punishments allotted for theft as the essential means for achieving the goal of preservation of individual material wealth.

The rest of the *maqāṣid* pertain to the individual family, the greater Muslim community (*ummah*), and general humanity. At the family level, he notes seven *maqāṣid*: (i) ordering relations between the sexes; (ii) preserving progeny; (iii) achieving harmony, affection, and

compassion; (iv) preserving family lineage; (v) preserving personal piety within the family; (vi) ordering the institutional aspect of the family; and (vii) ordering the financial aspects of the family. At the Muslim community level, there are seven *maqāṣid* as well: (i) the institutional organization of the *ummah*; (ii) maintenance of security; (iii) the establishment of justice; (iv) the preservation of religion and morals; (v) the promotion of cooperation, solidarity, and shared responsibility; (vi) the dissemination of knowledge and the preservation of reason; and (vii) the development and population of the earth, and the preservation of the *ummah*'s wealth. Finally, at the broader humanity level, Attia identifies five *maqāṣid*: (i) promoting mutual understanding, cooperation, and integration; (ii) realizing human vicegerency on earth; (iii) achieving world peace based on justice; (iv) promoting international protections for human rights; and (v) disseminating the Islamic message. He does not detail the essential means for attaining these *maqāṣid* in a systematic way. Rather he indicates that the means must be identified based on critically analyzing scripture and society together.

The *Maqāṣid al-Sharīah* and the Inherited Canon

While I have sketched out two models for the *maqāṣid* and noted essential aspects of general *maqāṣid* theory above, it is important for the reader to know that other models, each with their own nuances, exist. For example, al-Ghazālī, who preceded al-Shāṭibī, details a *maqāṣid* framework in various works and extensively discusses how the existence of core identifiable rationale for Divine law is widely accepted by Islamic jurists across the schools, and is intrinsic to the practice of the established *uṣūl* of *qiyās*. His 'innovation' was to move slightly upward from case-specific rationale to consider general purposes of the law and delineate how these may be correctly surmised and applied.[50] A more recent scholar, the Tunisian theologian-jurist Muhammad al-Tahir ibn ʿAshur (d. 1973), developed a full theory for

the *maqāṣid* that builds upon al-Shāṭibī's model by slightly expanding the meaning of the term *maṣlaḥah*, designating criteria for assessing benefits and harms upon which new rulings can be based, and expanding the number of essential *maqāṣid*.[51] Although these and other models share general features, each may offer slightly different platforms for engaging biomedicine and merit further study.

More important to recognize is that the *maqāṣid* frameworks did not originate in an intellectual vacuum. As illustrated by the preceding reference to al-Shāṭibī's predecessor, al-Ghazālī, there are significant connections between *maqāṣid* and *uṣūl al-fiqh* across the four Sunni schools of law. Indeed, all theorists must link their models to the inherited canon of legal constructs and devices, accepted theological doctrines related to law finding, and juridical practices. Without such backing, their frameworks would be dismissed off-hand by the very audience they seek to influence, practicing Islamic jurists. Indeed, clarifying linkages between *maqāṣid* theory and the legal schools provides theorists with the requisite cover needed to claim continuity with the historical tradition. Hence, early theorists painstakingly described how public interest was already deemed a valid grounding for Islamic law in the Shāfiʿī and Ḥanafī schools of law in their construct of *istiṣlāḥ*. Thus, the consideration of human interest in law finding was not novel. Similarly, rational inference, *istiḍlāl*, was an accepted modality of interpreting and extending scriptural commands within the Mālikī and Shāfiʿī schools. Accordingly, using induction from scriptural texts to identify the overarching purposes of the law should not be seen as objectionable innovation. And the genealogy of the *maqāṣid*, in application, is also traced to the Ḥanafī concept of *istiḥsān*. Additionally, as noted above, the *maqāṣid* are closely linked to the devices of *ḥikmah*, *ʿillah*, and *maṣlaḥah*, which are readily utilized across the schools. It is beyond scope to detail these connections and compare how these ideas work within *uṣūl al-fiqh* and within *maqāṣid* frameworks. Rather the forgoing suffices the aim of illustrating the importance and existence of links between the *maqāṣid* and the *uṣūl*.

It is also worth mentioning that the project of theoretical conceptualization of *maqāṣid* has not come to an end. To be sure, Ibn ᶜAshur's monumental work exemplifies the vigorous continued revision of *maqāṣid* theory. He sought to fill in gaps in al-Shāṭibī's theory, and subsequently, Attia's model is heavily influenced by Ibn ᶜAshur's as he sought to embellish upon it. Here, too, an intellectual continuity exists.

That said, although the *maqāṣid* can find substantiation within traditional *uṣūl al-fiqh*, the ideal relationship between the *maqāṣid* and *uṣūl al-fiqh* is subject to differing views. Early classical originators/expositors of *maqāṣid* theory, such as al-Ghazālī, conceded the *maqāṣid* no independent status in generating the law, rather these inductively derived purposes were to be part of a law-finding process involving *qiyās* (juristic analogical reasoning). The theoretical framework was thus considered to be a subordinate discipline of *uṣūl al-fiqh* and part of its formal-procedural approach to ijtihad.

Later classical jurists, namely, the Hanbali scholar Najm al-Dīn al-Ṭūfī (d. 1316) saw the *maqāṣid* as substantive-teleological tools for producing new laws and placed the framework alongside established *uṣūl al-fiqh* methods. Yet, he restricted the independent application of the *maqāṣid* to instances where traditional methods were silent or equivocal. Even the legal theorist, al-Shāṭibī did not claim that his framework could supplant traditional *uṣūl al-fiqh* methods. According to Felicitas Opwis and Anver Emon, both scholars of Islamic law and legal history, classical jurists were adamant about not giving the *maqāṣid* epistemic authority to create law afresh out of theological concerns. They worried that doing so would involve claiming that they had successfully captured Divine intent and, according to themselves (and fallible human reason), excessive legal authority. Rather, the *maqāṣid* were better put to use explaining established fiqh, and in this way, defending existing laws from rational inquiry.[52] At most, the *maqāṣid* could serve as cognitive checks assessing the output of *uṣūl al-fiqh*.

It is only in the modern period that Islamic scholars such as ibn ᶜAshur argued for an independent discipline of *maqāṣid* that supplants *uṣūl al-fiqh* in ethico-legal deliberation.[53] Taking up this cause the contemporary legal scholar Mohammad Hashim Kamali contends that the *maqāṣid* approach to law finding represents a distinct path separate from *uṣūl al-fiqh* for understanding the Sharīᶜah. Yet, recognizing marginalizing *uṣūl al-fiqh* is a bold intervention, he suggests that the two disciplines "can enrich and endorse one another."[54]

As we will see in subsequent chapters other Muslim thinkers unabashedly promote the independent use of *maqāṣid* in ethical deliberation, for policy generation, and even to recalibrate and reform extant fiqh.

Having now provided some historical notes as well an overview of the *maqāṣid al-Sharīᶜah*, we can proceed to engage with biomedicine and contemporary healthcare in the next chapters.

3

A MAQĀṢID-BASED VIEW OF HUMAN HEALTH IDENTIFYING THE GOAL(S)

The Arabic word *maqṣad* refers to an objective or an end goal.[1] Having described biomedicine in broad strokes, we can now turn our attention to the relevance of the *maqāṣid* to the ultimate aim of biomedical practice: improving human health. Indeed, this ultimate aim is shared across all sectors in healthcare delivery with each sphere employing different means to that end. Biomedical researchers study the human body and utilize the biosciences for the purposes of better understanding human anatomy and physiology, and for identifying how diseases impact bodily functions and human health. Relatedly, clinicians examine the body and prescribe therapeutics in order to restore or improve the health of their patients. Moreover, health policymakers enact legislation to regulate biomedical industries and clinical practices seeking to protect and improve societal health. In light of these stakeholder's roles, biomedical knowledge and practices in each of these areas individually, and on the whole, are organized to advance human health; in other words, the social organization of biomedicine is aimed at improving health. Yet, notions of health vary across time and culture, human health can be divided into various subcomponents, and multiple features of society impact an individual's health. As we deliberate over how the *maqāṣid* can inform health and healthcare, we must first delve into concepts and determinants of health.

Biomedical Conceptions of Human Health

From antiquity to the modern age, our understanding of what we are has continually evolved and our conceptions of health evolve with

these models of the human being. Considering the human being to be a body with an emergent property of consciousness, or an other-worldly spirit contained within a temporal body, or a special type of biological creature that needs social interaction, prefigures notions of health.

Almost universally throughout time, the idea of balance has been core to notions of health. Health obtains from being in balance internally and externally; in other words, health is an attribute of a balanced being. Ancient Greek, Indian, and Chinese medical systems all saw disease and illness as byproducts of imbalance. Accordingly, the therapeutics offered by these systems sought to correct the 'disorder.' Some Greek philosophers privileged the physical dimension of health, noting that the harmonious function of one's organs was required to be healthy, while others held that a sound mind was pre-requisite, thus signaling that good relations with kith and kin was needed to be truly healthy. In the Middle Ages, the religious and spiritual dimensions of health gained prominence through the Church's role in caring for the sick and the effectiveness of herbal remedies offered by monks and other religious orders. Even still the notion of balance remained core to health because spiritual health required being in balance with God and nature.

In the eighteenth and nineteenth centuries, a more functional dimension emerged and began to dominate the definition of health. It was functional in the sense that health served certain purposes within society. For example, rapid industrialization in Europe and the United States added an economic dimension to health, since a healthy labor workforce was critical for effective production and thus for the functioning of society. Being free from ill-health also allowed workers to continue to earn full wages and afford upward social mobility. At the same time, advances in the biosciences, such as the ability to see bacteria, closely aligned with a mechanistic worldview resulted in predominant notions of human health being linked to optimal physical function.

The modern era's conception of health extends beyond maintaining balance and optimizing function to include psychological dimensions. Health is now more readily related to one's capacity for self-fulfillment and flourishing. For example, poor mental health is not only associated with psychosis and pathological behaviors, it is also tied up in one's negative perceptions of personal happiness and well-being.

The foregoing discussion underscores the idea that before delineating what constitutes human health, a scholar must flesh out a model of the human being. That model identifies the dimensions of the human with respect to its internal nature and its relationship to the external environment. Ill health can then be viewed as disturbances in the balance between and among the internal aspects of the human being and/or its relationship with the external environment. Or it can be conceived as the malfunctioning of the internal components of the human and/or how they perceive the external environment.

Arguably, the most widely accepted definition of health is the one offered by the World Health Organization (WHO). The WHO's definition is positivist where "health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[2] This definition acknowledges various components of the human (i.e., physical, mental, and social) with the term "well-being" subtly hinting at the importance of harmonious balance between these components. This definition, however, is not without controversy, particularly because it does not explicitly acknowledge a spiritual aspect to the human. Now, on the one hand, some note that a spiritual dimension to health is subsumed within the terms "mental" and "social," and thus implicit to WHO's model; but others contend that the WHO's neglect was purposeful. As a transnational institution, the WHO's primary goal was to motivate governmental bodies to provide healthcare to society. Hence, the more concrete aspects of health, i.e. physical, mental, and social, were privileged in WHO's

definition because they are more amenable to organize healthcare provision around. In contrast, the spiritual dimensions of health are more variable across cultures and somewhat intangible; and, as a result these dimensions are less amenable to direct care services.[3] Accordingly, the WHO did not add this dimension for fear of losing motive force due to lack of consensus about the presence of a spiritual dimension of health and how it might be attended to by healthcare. Nonetheless, the WHO does not entirely ignore or leave unacknowledged the spiritual dimension of health and even explicitly acknowledges, particularly in the realm of palliative and end-of-life care, spiritual determinants of health.[4]

As noted in Chapter 2, while biomedicine privileges the body and the physical aspects of health it acknowledges that physical maladies can have psychological manifestations. The healthcare system associated with this biomedical model thus contains practitioners that tend to the physical as well as the psychological aspects of the human being. The social and spiritual aspects of health, on the other hand, are variably addressed.

While biomedicine certainly dominates healthcare discourse and practice today, even in Muslim lands during the classical period the bedrock of medical practice was founded upon the physical dimension of health. For example, a medical student training manual authored by the prominent Persian physician Ibn Hindu (d. 423/1032) called "The Key to Medicine and a Guide for Students" (*al-Miftāh al-ṭibb wa minhāj al-ṭullāb*) conveys consensus about "medicine [being] a profession that deals with human bodies and brings them good health."[5]

Consequently and arguably, there is no clear dividing line between 'new and old' or 'Muslim and Western' notions of health. Rather, any given society at any given time holds any number of distinct understandings of 'the human being.' Each of these understandings generates its own unique concept of human health, and the various healthcare systems operating within society base their

practices upon these divergent understandings. Multiplicity and plurality are the norm. Therefore, a conception of human health based on the *maqāṣid* could readily stand alongside other conceptions of health and enrich the discourse. The remainder of this chapter is devoted to deriving such a notion of health and examining how it aligns with others that presently animate biomedicine.

A Note on Sources and Methods

Before building out human health from the *maqāṣid* a few notes on research sources and methods are in order. To derive notions of health I draw upon the *maqāṣid* theories of Abū Isḥāq al-Shāṭibī and Jamal al-Din ᶜAtiyah (Gamal Eldin Attia). With respect to al-Shāṭibī, I primarily examine *al-Muwafaqqāt fi Uṣūl al-Sharīᶜah* ("The Reconciliation of the Fundamentals of Islamic Law") and contemporary commentaries on this work.[6] My reference point for Attia is his treatise, *Nahwa tafᶜil maqasid al-shariᶜah* (*Towards Realization of the Higher Intents of Islamic Law: Maqāṣid al-Sharīᶜah, A Functional Approach*).[7] I chose these authors and works because: (i) they are accessible both in Arabic and in English translation; (ii) the frameworks contained within these texts are relatively well-fleshed out by the authors; and (iii) they provide approximate bookends in the *maqāṣid* discourse, with the former offering a classical 'original' perspective of the theory and the latter a contemporary revision.

Furthermore, I have made the focus of my task to draw out the essential (*ḍarūrī*) aspects of health. I focus on these dimensions because *maqāṣid* theorists hold societal leaders to be morally obligated to protect and preserve these aspects of health. Additionally, both theoretical frameworks consider the essential aspects of the *maqāṣid* to be timeless. Given their immutable quality, delineating the essential aspects of human health is, then, more useful than identifying the ancillary necessary and/or enhancing dimensions which are subject to change. In order to identify the essential components of health, I focus on

discussions pertaining to the preservation of life and to the preservation of the intellect and/or mind.

I readily acknowledge that my purposive approach introduces limitations. Restricting my sources to two authors, and to two texts, may overlook elaborations of the *maqāṣid* found elsewhere. Similarly, analyzing the content of a few higher objectives may miss discussions about the health-related aims of the others. Moreover, focusing solely on the essential dimensions of human health provides a somewhat incomplete conception of human health. Nonetheless, given that the aim of this monograph is to initiate research and discussion, my examination should provide ample foundations for future work.

The Essential Aspects of Preserving Life and Preserving Intellect: Imam al-Shāṭibī's Account

Preserving life (*ḥifẓ al-nafs*) entails multiple duties related both to establishing the conditions for human life to exist and to ensuring against its termination. Al-Shāṭibī sets out several ways this objective can be actualized through Islamic law. The first three means to preserve life are primarily the duty of societal leaders. The first way in which life is preserved is by legitimating the 'production' of life by means of laws that establish valid procreative relationships (e.g., marriage laws). The second method pertains to maintaining the conditions for life to exist. In this area, the specific means to preserve life are laws and policies related to the provision of acceptable food and drink. The provision of clothing and shelter which ensure human survival may also be included within this category.[8] The preservation of life also demands protecting against its 'negation' by criminalizing the taking of life. The parameters of criminality and justice in this third category of means falls solely within the authority and remit of societal leaders, since individuals should not become vigilantes. While this third method is sharply limited to societal leaders, individuals and families could accomplish the second method, that is, the

provision of essential goods, as well. Nonetheless, according to al-Shāṭibī, Islamic law holds societal leadership as morally obliged to enact laws and policies that attend to these three domains.

Further expounding on the means to preserve life at the family level, al-Shāṭibī categorizes as means of establishing life actions taken to ensure one's children enter into valid marriages, know the rules of divorce, and are protected from sexual misconduct, while, on the other hand, ensuring one's children do not eat harmful items are means to maintaining life. As these actions are moral obligations related to the preservation of life at the family level, they are thus the responsibility of the head of the household.

The higher objective of preserving intellect operates at two levels: at the individual level, refraining from intoxicants; and, at the societal level, issuing laws that prohibit intoxicants and intoxication.[9] Hence the essential duties stemming from this objective produce moral obligations of individuals as well as societal leaders. Like his overall theory, al-Shāṭibī finds support for these means and categories within the Qur'an and Sunnah.

The Essential Means of Preserving Human Life and the Mind According to Attia

Attia's vision for the moral obligations related to the preservation of human life is predicated on two underlying concepts: "the right to life, [and] or the sanctity of the body."[10] Like al-Shāṭibī, Attia charges societal leaders with the moral duty to achieve these goals and delineates several ways to do so. He details three categories of essential means. The first category entails establishing deterrents such as penalties for killing and causing bodily harm, as well as the legal prohibition of suicide. The second category of means relates to the maintenance of life and mirroring al-Shāṭibī he places the provision of food, drink, clothing, and shelter in this domain. Lastly, he adds a third category of essential means covering actions that protect against 'mortal dangers' such as fire, drowning, and car accidents.[11] Again, the moral obliga-

tion to preserve life calls for societal leaders to: (i) deter murder and bodily harm; (ii) ensure individuals are secure from environmental threats; and (iii) forestall mortal threats.

In what might be called an 'update' of al-Shāṭibī's (medieval) model, Attia's model explicitly identifies aspects of healthcare to be essential means of preserving life. He states that the "protection against infectious diseases" and the "provision of treatment for those afflicted by illness or accidents," as well as protections against "radiation" are all essential means for preserving human life.[12] These actions seem to lie within the third means category of forestalling mortal threats. Within the first means category related to bodily sanctity, he reasons that the "protection of certain parts of the body from harm or damage" is required because "damage to them would lead to the near inability to benefit from the life one has."[13] In this way he subsumes certain aspects of contemporary healthcare within the overall means to preserve life.

The essential means for achieving the higher objective of "consideration of the mind"[14] include: (i) developing the mind through scientific education by building academies and institutions that support learning and instruction; (ii) refraining from and protecting against mind-altering intoxicants and untoward cultural influences; and (iii) performing intellectual acts of worship. While no specific aspects of healthcare are explicitly mentioned within these means, they can be related to healthcare delivery, which I will demonstrate below using the example of protecting against intoxicants.

The Essential Dimensions and Determinants of Human Health

The outlines provided by al-Shāṭibī and Attia of the overall components constituting the *maqāṣid* for the preservation of human life and the preservation of the intellect/consideration of the mind are quite similar. Both assert that the provision of food, drink, clothing and shelter are essential for human survival—and thus declare such

provision to be morally obligated under Islamic law. Al-Shāṭibī appropriately recognizes that human life is created through procreation and emphasizes that laws defining the procreative relationship are also part of the ethical responsibility to preserve life. While Attia appears to neglect this detail, he adds healthcare provision as an essential component of living out the moral duty to preserve life. Using these means of preserving life and intellect/mind as an epistemological foundation, we can build out an account of the dimensions and determinants of human health.

As noted at the beginning of this chapter, the *dimensions* of human health are derived from conceptions of the human being. The *determinants* of human health, on the other hand, are the personal, social, economic, and environmental factors that influence individual health status. I contend that the *maqāṣid* theories can furnish a conception of human health based on the methods and means they identify to preserve human life and intellect, and that they also speak to the determinants of health based on the same means and methods. In what follows I first describe conceptions of human health and then connect them to the determinants of health.

The Essential Aspects of Human Health Based on al-Shāṭibī's Model

The various components of al-Shāṭibī's framework, when considered from a health perspective, can be correlated with various aspects of human health. To review: according to al-Shāṭibī's theory, life is established by legislating the procreative capacity of the human, it is sustained through sufficient food and drink, and it is secured by the provision of clothing and shelter. When we map these onto aspects of health, it becomes clear that reproductive health is central to al-Shāṭibī's theory: if humankind lost the capacity to procreate then life would be universally at-risk. Further, preventing starvation ("ensuring survival from within"[15]) correlates with physical health and nutrition, and the provision of clothing and shelter relates to bodily

integrity and the social and structural determinants of health. According to al-Shāṭibī, although protecting an individual's faculty of reason is part of the preservation of intellect (ʿ*aql*), it is also part of the preservation of life because human reason cannot exist without human life.[16] Hence, core elements of the *maqāṣid* of preserving the intellect such as the prohibition of intoxicants can be appended onto notions of health within al-Shāṭibī's framework.

Converting these notions into a mental image, according to al-Shāṭibī's framework, a person with the essential aspects of health intact correlates to a person who is minimally nourished and clothed, has the physical capacity for procreation, is free from the influence of intoxicants, and resides in a dwelling that protects him from the elements.

The Essential Aspects of Human Health Based on Attia's Model

Attia's theory also has strong foundations upon which the essential aspects of human health can be built. He is explicit that protection against infectious disease and providing healthcare to combat illness are essential to preserving human life because these are mortal dangers that threaten the existence of life. He also asserts that the provision of food and drink are essential, signaling the importance of nutrition to life. Additionally, he prioritizes bodily integrity by commenting that protecting against radiation exposure and trauma, as well as preventing organ damage, are critical means for preserving human life. Another element of health can be gleaned from Attia's framework is mental health. Meting out the moral dimensions of the consideration of the mind objective, he calls for avoiding intoxicants and preventing brainwashing. Since the consideration of mind objective is subsidiary to the preservation of life objective, preserving the faculty of reason falls second to maintaining bodily integrity and preventing mortal injuries and starvation within his model.

In summation, if we combine all the facets of Attia's model into a single image, a person who possesses the essential aspects of health would be someone who is minimally nourished, clothed, free from drug addiction and mind control, and resides in a dwelling within a community that is safe from murder and assault.

Comparing the Two Conceptions of Human Health

The two conceptions share much in common and affirm that Islamic law recognizes the importance of health. The minimalist visions presented demonstrate that food security, the provision of shelter and clothing, and penal repercussions for life-taking are, from an Islamic perspective, essential to human existence. These base level of essential conditions needed to preserve human life, as defined by Islamic law, are then built upon by the necessary (*ḥājī*) and enhancing (*taḥsīnī*) elements to allow for a flourishing, and potentially religious, life. Those seeking to build a philosophy of public health and biomedicine from an Islamic perspective should take heed from hierarchical schema outlined in the *maqāṣid* models so that the *ḥājī* and *taḥsīnī* elements are not focused on to the exclusion of the *ḍarūrī*, because without a foundation no edifice can stand. Food security deserves more attention than the teaching of table manners, and outlawing murder is more important to human survival than providing for cosmetic surgery. Indeed *maqāṣid* models might prove useful in policy and program development.[17]

The general picture of health looks nearly identical from the perspective of both theories: the health status of an individual with the essential dimensions of health intact would be the same based on each theory. Fulfilling the essential moral duties of preserving life and intellect generates a base level of human life that is nourished, secure from environmental threats, and mentally sound. Hence a *maqāṣid*-based model for human health includes physical health, mental health, and places a strong emphasis on nutrition.

At the same time, reproductive health seems to be a critical component of health within *maqāṣid* thought. One may argue that procreation is necessary for human life to exist and, since Attia's theory does not discuss procreation as an essential means for preserving life, his model does not adequately prioritize reproductive health. But this absence, it turns out, can be explained by the fact that the preservation of progeny is an objective that pertains to the family level in his theory, and our derivation was based on individual-level objectives and accompanying means. If we include the family level of higher objectives, then Attia's model would lead to reproductive health being an essential dimension of health, just as in al-Shāṭibī's model. The priority accorded to human reproduction in both frameworks underscores that reproductive capacity is critical to Islamic conceptions of health. Muslim thinkers seeking to fashion an Islamic philosophy for healthcare should consider the profound connection between reproductive health and the preservation of life within *maqāṣid* thought.

In contrast to Attia, al-Shāṭibī fails to explicitly discuss healthcare provision as important to preserving human life. One may account for this oversight by noting that thirteenth-century medical care was not particularly effective and thus would not have been considered essential to human life at the time. On the other hand, medical technology, healthcare professionals, and hospitals did make important contributions to society during al-Shāṭibī's lifetime, particularly in his home of Andalusia and in Muslim centers of learning in Baghdad, Damascus and Cairo.[18] Given this, his non-inclusion is curious, and in my view it may be that al-Shāṭibī reasoned that healthcare resided at the level of necessary objectives and means rather than at the essential level.

Yet, it is also important to note that not only do the models presented here describe only the essential (*ḍarūrī*) aspects of preserving human life (and hence require building out for a more complete model), but that they might be dated. In other words, contemporary

knowledge about social and health conditions and policies can inform the classification of means for preserving human life (and thereby health) into *ḍarūrī*, *ḥājī*, and *taḥsīnī*. And, according to al-Shāṭibī, these data can provide insight into the human benefits and harms that are secondary objectives carried alongside the primary *maqṣad* of preserving life. Consequently, interdisciplinary efforts are needed to more fully develop visions of human health and well-being based on the frameworks and initial conceptions presented by these authors.

Focusing on the Determinants of Health

Respectively, the two models overlap in deeming the provision of food, clothing, shelter, and security from intoxication as essential components of the moral objective of preserving human life. This focus on social conditions is particularly notable because it addresses determinants of health.

Over the last few decades, health researchers and healthcare policymakers have recognized that differences in health outcomes between groups within society are, in large part, due to social and economic factors that disadvantage some groups more so than others.[19] This follows from the fact that an individual's socioeconomic circumstances contribute significantly to his/her health status and that the association between socioeconomic conditions and health outcomes may be stronger than the link between either genetics or personal behaviors and health outcomes.[20] Given the determinant force of socioeconomic factors, remedying health inequalities and healthcare disparities requires intervening upon socioeconomic conditions that obstruct healthy lifestyles and healthcare access for disadvantaged populations. Researchers are thus increasingly trying to identify the impact of social and economic characteristics such as educational attainment and food insecurity on healthcare outcomes in order to design effective interventions.

Similarly, policymakers and public health intervention specialists increasingly seek to translate the knowledge of social determinants of health into health education programs. Indeed, providing stable housing and ameliorating food insecurity go a long way in improving the health status of individuals and their ability to manage disease and illness.

Both *maqāṣid* models give primacy to the social determinants of health by viewing them as integral to the objective of preserving human life. Accordingly, Muslim thinkers seeking Islamic grounds for healthcare initiatives that attend to the social determinants of health can find support in the *maqāṣid*.

Concluding Remarks

In closing, the *maqāṣid* frameworks provide actionable insight into dimensions and determinants of health. They prioritize physical, mental, and reproductive aspects of human health while affirming the importance of providing the socio-economic conditions needed for life to exist. A more public health and social determinants-oriented healthcare system also appears to align with the *maqāṣid*-based moral obligations of preserving human life and intellect. In Chapter 4, we will build upon conceptions of health to discuss health policy from a *maqāṣid* point of view.

4

A MAQĀṢID-BASED HEALTH POLICY AGENDA: STRUCTURING SOCIETY TO ACHIEVE THE GOAL(S)

Transformations within socio-political systems, advances in technology, and increases in scientific knowledge motivate changes in social norms, practices, and structures. These kinds of societal reconfigurations both spur individuals to reevaluate their currently held values and personal beliefs as well as stimulate societal leaders to reconsider best practices in governance and policymaking. Such moments of change also push religious traditions to adapt and evolve. Indeed, religious texts and ethical systems are oft-looked to for guidance when individuals grapple with thorny questions emerging from new social, cultural, and political realities. These scriptures and the values they house are, in turn, reevaluated, reinterpreted, and repackaged by scholars as part of an ongoing enterprise to remain relevant. And, indeed, bringing 'ancient' wisdom to bear upon 'modern' issues is part and parcel of the reform project that contemporary *maqāṣid* writers are engaged in.

Recall that the *maqāṣid al-Sharīᶜah* represent the overarching aims of Islamic law. Islamic theologians and legists agree that Islamic law, as a system derived from revelation, serves to protect human interests in this world and the hereafter. According to the former Grand Mufti of Egypt, Shaykh Ali Jumah, the *maqāṣid* reflect specific human welfare interests that Islamic laws must preserve and thus are the law's most vital concern.[1] Consequently, divine intents are connected to the (best) interests of humanity, and Islamic ethico-legal theorists labor to identify specific human interests connected with scriptural injunctions in order to build out frameworks that extend Islamic law to cover issues not directly addressed by scripture. The notion of servicing human interests brings the *maqāṣid* into connection with the construct of *maṣlaḥah*.

As *maṣalih* (the plural form of *maṣlaḥah*) and *maqāṣid* are parallel concepts, the same debates revolve around both. Islamic legal theorists hold differing views on whether the legal construct of *maṣlaḥah* can be used independently to ground legal rulings; the case is the same with the *maqāṣid.* Similarly*,* there is significant controversy about the legitimacy of *maṣalih* and *maqāṣid* that are not explicitly validated by Qur'anic verses or Prophetic statements.

Nonetheless, many classical legists and contemporary theorists contend that identifying *maṣalih* and *maqāṣid* is the requisite first step in deriving Islamic laws related to *muᶜamalāt* (human relations and transactions), *ᶜadāt* (human practices), and even *jināyāt* (criminal law). Because Islamic law has both an ethical and a legal dimension[2] and it carries a moral vision for both individuals and society, it can also serve as a foundation for social policy.

Accordingly, this chapter advances the conversation between the *maqāṣid al-Sharīᶜah* and biomedicine to the health policy register. Multiple writers have discussed how frameworks based on the *maqāṣid* intersect with human rights and economic policy.[3] On the other hand, conversations regarding health policy and the *maqāṣid al-Sharīᶜah* are few and far between. The scant literature focuses on vaccination. These articles advance alignment between vaccination policies, both 'hard' mandates and 'soft' requirements, and the cardinal objective of preserving life because vaccination prevents societal disease transmission and reduces individual-level morbidity and mortality. The quantity of solid empirical data around the benefit of particular vaccines, authors argue, produces a *maqāṣid*-based moral obligation for individual Muslims to obtain appropriate vaccines and for Muslim leaders to promote vaccination among the populace.[4]

Drawing inspiration from these scholars, this chapter builds upon the preceding chapter's discussion of health to develop a *maqāṣid*-based approach to health policy. Specifically, I will connect the goals and means related to the essential higher objective of preserving life (*ḥifẓ al-nafs*) to scientific literature about leading causes of human

mortality. In so doing, I contend that a health policy agenda that intervenes upon the leading causes of human mortality is fully supported by the *maqāṣid al-Sharīʿah*. More concretely, I will demonstrate that both Abū Isḥāq al-Shāṭibī's traditional framework as well as Gamal Eldin Attia's more contemporary model support action against the leading causes of human mortality.

Review of the Preservation of Life as an Essential Higher Objective

Indisputably, preserving human life is a core aim of Islamic law. The Qur'an and Sunnah are replete with references to the sacredness of life (e.g., Qur'an 6:151 and 17:33), the honor and dignity accorded to the human being (e.g., Qur'an 17:70), and penalties for murder (e.g., Qur'an 2:179). These scriptural passages provide the evidentiary grounds for Islamic legists to sanctify human life and provide the basis for *ḥifẓ al-nafs* to be an overarching objective of Islamic law. Thus, despite offering slightly different visions for what it entails and how it is achieved, both Abū Isḥāq al-Shāṭibī and Gamal Eldin Attia both locate the preservation of life at the center of their theoretical frameworks.

As explained in the preceding chapter, al-Shāṭibī sets out three ways to actualize the preservation of human life. First, procreation (the means by which life is produced) requires legitimation; procreation cannot be universally outlawed.[5] Further expounding on this moral mandate, al-Shāṭibī states that ensuring one's children enter into valid marriages, know the rules and processes of divorce, and are protected from sexual misconduct is subsumed within establishing life. Second, preserving life requires its maintenance by securing food and drink, and educating oneself and one's progeny about lethal foodstuffs. The third way is by protecting against external threats to the human body and the life contained within it through securing clothing and shelter and criminalizing assault and murder.[6] Bolstering the argument for capital punishment, it is notable that the Qur'an

states that the law of retribution (capital punishment after homicide) is intended to protect life "for in [the law of] just retribution (*qiṣāṣ*) O you who are endowed with insight, there is life [for you] so that you might remain conscious of God (2:179)."[7] It is important to note that the preservation of human life is second to the preservation of religion in al-Shāṭibī's schema because if religion is not preserved then the purpose of creation is thwarted.[8]

Attia, on the other hand, holds that, at the individual level, the preservation of human life is the foremost objective. He contends that faith is subsidiary to life; in other words, without human life, there can be no embodied religion. Attia's framework categorizes the means to achieve *maqāṣid* into those that are essential, necessary, or enhancing (for al-Shāṭibī, the *maqāṣid* themselves are classified into these categories). He details the essential means for the preservation of human life in the following way.

First, the provision of security is essential. Rampant murder, excessive risk of bodily injury, or the lack of penalty for suicide all threaten and devalue human life, and thus must be prevented by laws and social policies. The second essential means relate to the maintenance of life by providing food, drink, clothing, and shelter. He also indicates that protecting against "mortal dangers" such as fire, drowning, car accidents, and the like are essential methods for protecting life.[9] He reasons that the "protection of certain parts of the body from harm or damage" is required because "damage to them would lead to the near inability to benefit from the life one has."[10] Added to this are aspects of healthcare. He states that the "protection against infectious diseases" and the "provision of treatment for those afflicted by illness or accidents," as well as protections against "radiation" are all essential to preserving human life.[11]

Building Out a Health Policy Agenda from the Higher Objective of Preserving Life

Mechanisms Within al-Shāṭibī's Theory

A detailed study of Qur'anic injunctions and Prophetic statements allowed al-Shāṭibī to deduce the essential objectives of Islamic law. However *maqāṣid* can be discerned by several other means. In his theory he acknowledges that there are primary and secondary objectives undergirding the Lawgiver's commands with the primary being explicit to the text and the secondary (able to be) inferred. These secondary objectives qualify as valid intentions of the Lawgiver so long as they strengthen, reinforce, and support the primary ones.[12] Hence inference is a valid method to derive secondary objectives. Additionally, *maqāṣid* can be gleaned by human reason independently from scripture. Recall that for al-Shāṭibī, a Mālikī legal theorist, this equates to grounding moral obligations in the construct of *maṣlaḥah mursalah*. He claims, "(when the Lawgiver is silent) we have recourse to an examination of the different meanings of *maṣāliḥ* (human interests). Anything in which we discover an interest, acting upon *maṣāliḥ mursalah*, we accept, and anything in which we find an injury, again acting on the *maṣāliḥ*, we reject."[13] These secondary objectives gleaned from inference or arrived at by using independent human reason fall into the categories of necessary (*ḥājī*) and enhancing (*taḥsīnī*) objectives. The necessary *maqāṣid* beget facility in human life, while the enhancing ones support the refinement of human character and practices.[14] Al-Shāṭibī's theory thus includes second order necessary or enhancing *maqāṣid* that sit alongside the essential objective of preserving life. The validity of candidate objectives rests on their not contravening any essential higher objectives or valid human interests identified in scripture, and they can be inferred from scriptural sources or based on quasi-utilitarian reasoning.

I believe that al-Shāṭibī's methodology surrounding the discernment of second-order necessary and/or enhancing *maqāṣid* provides a passageway through which empirical evidence about the leading causes of human mortality can specify objectives of Islamic law. While preserving human life by means of penalizing murder, legitimating procreation, or providing food and drink are sourced within scripture, one could argue that the protection of life also involves intervening upon conditions that lead to death. Empirical evidence can meet the threshold for certain knowledge in Islam[15] and furnishes grounds for human reason to arrive at secondary objectives. Notwithstanding using human reason to make claims about benefits and harms based on knowledge of this world, one can argue that since the Qur'an emphasizes the value of life and prohibits the taking of life, in addition to preventing murder, intervening upon preventable causes of death is inferred from the text.

Within al-Shāṭibī's theory, necessary *maqāṣid* attached to the preservation of life are those that remove hardship and difficulty in living at a universal level. Surely addressing the leading causes of mortality does this by limiting morbidity from diseases, and it may also reduce mortality. In my view, preventing the leading causes of mortality can be classified as a necessary objective of Islamic law.

Mechanisms Within Attia's Theory

Attia considers the present epoch to be one where rapid social and technological developments, along with increased human knowledge, necessitate relying upon human reason to discern new, and further explicate the classical, *maqāṣid*. Indeed, he expanded al-Shāṭibī's theory because he saw it fell short in accommodating contemporary scientific understandings and societal mores. Though he advocates for the use of human reason and bringing in data from the social and natural sciences to assess harms and benefits to human life, he does not advocate for unfettered usage of reason in determining

the objectives of Islamic law. Instead, candidate *maqāṣid* are valid only when they: (i) do not conflict with a definitive scriptural text or another objective derived from such texts; and (ii) are clear enough that they can be applied consistently across time, person, place, and context. He further notes that if there is perceived conflict between a proposed objective and a scriptural source or an objective derived from it, established hermetical rules contained with fiqh should be used to substantiate or reject the proposed objective.[16]

Since Attia's theory places great importance on the means for accomplishing the higher objectives, the methodology and processes by which these means are identified is extremely critical. Here too, Attia suggests that rational evidences are sufficient. Yet, as a first step, standard *uṣūl al-fiqh* practices must be employed. Hence scriptural sources must be resorted to, for it is possible that scripture directly speaks to the importance of particular methods to preserve a human interest (see note regarding capital punishment above). Failing a scriptural source, conventions of analogical reasoning (*qiyās*) are utilized or a scholarly consensus sought.

When such methods do not provide answers about how to accomplish the *maqāṣid*, Attia proposes recourse to an "objective criterion" where the degree of benefits and harms associated with specific means are assessed. Wherever significant benefit is obtained or significant harm is removed via a particular means, that means is classified as an essential means. Minor benefits or removal of minor harms places the means within the enhancing category, while necessary means fall in between these two poles.[17] This schema for classifying means based on the harms and benefits they lead to enables Attia's theory to be malleable because the means can be placed into different categories based on context-specific empirical, social scientific, and other data. More importantly, allowing reason both to set *maqāṣid* and to categorize means by which these *maqāṣid* are achieved provides an entry-point for biomedical data and understandings to inform the conceptualization of the higher objective of preserving

life. As mentioned above, his model already specifies elements of a healthcare system as essential means for preserving human life.

It would appear that expanding these notions to include intervening upon the leading causes of mortality is consistent with his theoretical model. His theory allows for expanding the scope of the higher objective of preserving human life, or adding new objectives altogether. Consequently, one could argue that addressing diseases and conditions that significantly contribute to human mortality logically follows from the objective of preserving human life. Alternatively, one could claim that protecting against causes of human mortality is a 'new' objective because it accords with the preservation of life. Rather than expanding the scope of classical objective or specifying a new objective, a third way to integrate the idea of intervening upon the leading causes of human mortality would be to set this strategy as a means by which the preservation of life is secured. Indeed, addressing the leading causes of mortality would signify essential means because of the great benefits accrued and the significant harms forestalled from lessening the burden of diseases and conditions that account for the majority of deaths in the world.

Drawing Upon the *Maqāṣid al-Sharīah* to Address the Leading Causes of Human Death

Measuring the Health of Populations

There are a myriad of ways to measure population health. Each of these approaches, and the metrics they entail, provide valuable insights into critical aspects of societal health, but none provide a complete, comprehensive picture. Among these, measures of both life and of death are unquestionably invaluable tools for gleaning an overall sense of how inhabitants within a specific locale fare. One valuable indicator is life expectancy, as the average life expectancy

within a country represents a hybrid indicator of the health status of a country's population as well as the quality of healthcare services available within a country. Alternatively, instead of looking at data on life, public health officials may look to death rates. For example, adult mortality rates estimate the probability of dying between 15 and 60 years of age and reflect both population health status and quality of healthcare services. Neonatal mortality rates (deaths per 1,000 births within the first 28 days of life) similarly offer insight into overall newborn health and the healthcare they receive. Another measure that informs health policies and programs is data on the causes of death. These metrics allow for cataloging diseases that pose the largest threats and adversely impact society. Despite their robust yield of useful empirical data, mortality rates suffer from at least one major limitation: they do not account for the burden of disease caused by non-fatal maladies. Indeed, mortality is not the only or only important marker of health: morbidity is also a significant marker not to be ignored.

Health policymakers thus rely on various summary statistics or combinations of them to guide resources toward societal health improvement. Knowledge about what diseases afflict a specific country's population and what conditions contribute to death of the citizenry aids policymakers and other leaders in making decisions about what health services and education programs to design, how to allocate biomedical research dollars, and what policies to enact to decrease overall mortality. In summary, many different metrics are used to assess the health status of a population. Any or all of these measures can inform our understanding about how to preserve human life, and working to alleviate the leading causes of death appears fully consistent with *ḥifẓ al-nafs*.

Core functions of the WHO include monitoring the global burden of disease, analyzing health trends and determinants across the world, and advocating for policies that improve global health. In order to fulfill these roles, the WHO collaborates with national

governments and non-governmental partner agencies to collect and standardize data reporting of population health. Illustratively, WHO's Global Health Estimates (GHE) provide the latest available data on death and disability globally, by region and country, and by age, sex, and cause. These statistics provide an aggregate view of global health status and allow for cross-nationally comparing population health status. While the technical aspects of data collection and analyses lies beyond the scope of this chapter, it is important to recognize that these reports take into account a variety of data sources including child mortality statistics, data on communicable and non-communicable diseases, as well as reporting on epidemics and disasters.[18]

In 2019, the WHO reported that the top ten causes of death in the world from highest to lowest were: ischemic heart disease, stroke, chronic obstructive pulmonary disease (COPD), lower respiratory infections, neonatal conditions, trachea, bronchus and lung cancer, Alzheimer's disease and other dementias, diarrheal diseases, diabetes, and kidney disease.[19] The top cause, ischemic heart disease, is on the rise globally as it accounts for 16 percent of all deaths or nearly 9 million lives lost in 2019. Kidney disease, the last of the top ten causes of mortality, claimed about 1.3 million lives in 2019. Obviously, the burdens of each disease vary across countries, and by socioeconomic status, race/ethnicity, and biological sex.[20]

A *Maqāṣid*-based Health Policy Orientation

How might these data inform Islamic views on the preservation of human life? If we agree that the preservation of life is an essential higher objective of Islamic law then preventing the harms from these diseases and conditions aligns with the moral mandate to preserve life. Individuals and societal leaders would be obligated to address the mortality arising from these conditions through education, policy, and law.

Intervening upon these conditions can, arguably, be viewed as a secondary objective implicitly connected to the textually derived objective of preserving of life or, alternatively, as a necessary objective grounded in empirical data and human reasoning (either understanding adheres to al-Shāṭibī's theory). Then again, one could claim that deflecting harms from these conditions is integral to the preservation of life and that policies and programs that do so represent essential means to preserve human life (this strategy aligns with Attia's framework). Operationally, laws and policies that remove the harms from these diseases and conditions can be judged to be authentically 'Islamic.' Said another way, it can be reasonably argued, and ethically justified, that the promulgation of laws and policies that reduce death from these causes is consistent with the demands of Islamic morality.

Practically, a health policy agenda that addresses the leading causes of death can take on many forms, and the scope could be local, national, or even transnational. From an Islamic standpoint, one would need to look for strategies that are known to be effective in reducing death. With respect to empirical data, Islamic legists uphold the metric of dominant probability (*al-ẓann al-ghālib* or *ghalabat al-ẓann*) which indicates a greater than 50 percent likelihood of the desired outcome as a threshold for generating Islamic moral obligations.[21] Muslim stakeholders would thus need to canvas the literature for programs and policies that meet this greater than 50 percent effectiveness level for reduced mortality. Once identified, these programs and policies could be enacted with the backing of religious tradition.

Accordingly, an Islamic health action agenda could take innumerable forms. To provide a concrete example of what this might look like, I will lay out a hypothetical scenario using the global data discussed earlier.[22] It is noteworthy that at least three of the top ten causes of death are linked to smoking: respiratory system cancer, COPD, and lower respiratory infections. Smoking is also a risk factor for two other causes of mortality, ischemic heart disease and stroke. On this basis, a health policy maker could advocate for laws that restrict

smoking such as increasing sales tax on tobacco products or enforcing laws that limit the public marketing of tobacco products.[23] They could design public educational campaigns that increase awareness of the dangers of smoking and provide individuals with resources to stop smoking. At a more drastic level, the tobacco content within cigarettes could be regulated downwards or tobacco smoking could be fully banned.

The hypothetical policy maker would be 'Islamically' justified in enacting any of these policies provided that: (i) the strength of causal associations between smoking and respiratory cancers, lower respiratory infections, and COPD (and possibly ischemic heart disease and stroke) meets the threshold of dominant probability, and (ii) the effectiveness of the candidate policies and programs is substantiated to be above the 50 percent level.

In a similar fashion, high blood pressure is a well-known risk factor for four of the top ten causes of death: ischemic heart disease, stroke, kidney disease, and diabetes. Scores of studies establish a near-definitive association between high blood pressure and mortality from these diseases.[24] As such, Muslim state governments and public health officials could take a hybrid preventive health and clinical care approach to design comprehensive healthcare programs that educate individuals about managing their high blood pressure through diet and exercise, provide low-cost or no-cost medications to treat high blood pressure, and set up systems for monitoring disease progression so that early interventions can be enacted. By doing so, rates of ischemic and hypertensive heart disease, stroke, and diabetes will likely decline.

Officials could also adopt primary prevention strategies to lower the rates of high blood pressure among the population. This might be done by regulating salt additives in food production,[25] and mandating physical exercise classes[26] and education about healthy eating as part of school curricula. In this way, the number of people who develop high blood pressure might be reduced. Downstream reductions in

mortality from hypertension-related diseases could be reasonably expected from providing better healthcare and monitoring to individuals who already have the disease and by reducing the risk of developing high blood pressure through targeted lifestyle modifications such as inculcating healthy eating and routine exercise habits among the youth. The same caveats noted above apply here regarding the greater than 50 percent proven efficacy threshold for policies and strategies.

The policy strategy I advocate for links empirical data with ethico-legal imperatives within the Islamic tradition. In so doing, Muslims, as a religious community, would be motivated to get behind such programs and policies and see them as part of their living out their faith commitment in the public policy square. I want to underscore that this chapter's aim was not to exhaustively detail laws, programs, and/or policies that can address the leading causes of death. Rather, my aim was to sketch out how to search for and design programs that intervene upon the leading causes of death in accordance with the Islamic civilizational ideal of, and moral mandate to, preserve human life.

Conclusion

In this chapter, I set out to integrate Islamic theological frameworks and scientific data. I used conceptual models of the *maqāṣid al-Sharīᶜah* as the site for integration of knowledge. I outlined how leading theories of *maqāṣid* provide human reason (and thereby empirical evidence) a quasi-independent role in (i) determining the means to achieve scripturally derived higher objectives and (ii) identifying secondary higher objectives that support established ones. I then sketched out how laws, policies, and programs that address the leading causes of mortality cohere with the essential overarching objective of the preservation of life (*ḥifẓ al-nafs*). My demonstration was by no means exhaustive. I did not design a comprehensive health

policy and action agenda nor did I fully analyze the evidence supporting the strategies I suggested. And I also did not evaluate all of the many different conceptual models for *maqāṣid al-Sharīʿah*. Such forays are logical next steps that Islamic studies researchers and health policymakers should take together in order to integrate *maqāṣid al-Sharīʿah* and public health science more fully. This work, rather, has charted out a strategy for applying *maqāṣid*-based models to contemporary life and a path toward contextualizing Islamic law in light of developments in the human and social sciences. It also has the advantage of broad appeal to a diverse range of stakeholders: for Muslims and Muslim contexts, such policies and laws would be seen as part of a faith-based framework and grounded within Islamic law; for secular discourses at a transnational level or in plural dialogue, such laws and policies do not require scriptural rooting as their rationally grounded empirical foundations will garner support. Indeed, while scripturally consistent, the merit of such actions and policies is substantiated by social scientific theories, empirical data, and lived experiences. In this way, the outputs of *maqāṣid*-based frameworks can service secular and plural discourses.

5

MAQĀṢID-BASED MODELS FOR CLINICAL MEDICAL ETHICS: MORAL DELIBERATION AT THE BEDSIDE

Healthcare delivery in the modern area has been radically transformed due to the abundance of rapid developments in the fields of biotechnology and bioscience.[1] The therapeutics of today were unfathomable just decades ago: robot-assisted surgical techniques allow for safer and more effective surgery, stem cell transplants offer lifesaving cures for specific immunological diseases, gene editing technologies correct particular inherited disorders, and the list goes on. These spectacular innovations generally increase our ability to restore health, rejuvenate bodies, and facilitate human flourishing. And with these enhancements and increased capacity to intervene upon bodies and lives comes a new, and increasingly complicated, set of ethical questions. For example, while intensive care technologies may be able to forestall dying, is a life dependent on a ventilator that also requires constant sedation a life worth maintaining? Similarly, while cochlear transplantation can 'solve' congenital hearing loss, is such intervention always a good thing? In other words, should congenital deafness be reductively classified as a diseased state?

Bioethical questions such as these demand cogent analysis and nuanced answers.[2] Accordingly, patients, clinicians, healthcare policymakers, and other stakeholders seek guidance from philosophers, theologians, and other ethicists about the proper ordering of biomedicine with regards to questions of ethical propriety to policy and protocol to best practices. The global Muslim population is on the rise with current estimates noting Islam is the fastest growing religion[3] in the world and currently represents almost a quarter of the world's population.[4] As a result of this growth, both within Muslim majority contexts and in the diaspora, not only are more individuals seeking

out Islamic perspectives on biomedical issues, the population-level impact of Islamic bioethical perspectives is also broadening. To suffice the need for Islamic bioethical guidance many scholars are striving to delineate what the intellectual tradition can offer to contemporary bioethical discourses.[5]

This robust discourse between biomedical and Islamic worldviews takes many different forms within varied contexts and among a diverse set of stakeholders. It occurs in the halls of seminaries, classrooms of universities, at the bedside of patients, and even in the prayer rooms of mosques. It is captured within fatwas, journal articles, and books, and editorialized in newspaper articles, internet blogs, and podcasts. Indeed, the producers are many and come from a myriad of disciplinary backgrounds, including Islamic jurists, imams, Muslim physicians, chaplains, and social scientists. Similarly, the consumers of the discourse are diverse and include patients, clinicians, policymakers, and academicians, each consumer seeking guidance for slightly different purposes.[6] Tables 5.1 and 5.2 provide a typology of Islamic bioethics consumers and producers.

This multidisciplinary and multi-level discourse has recently generated numerous symposia, journal articles, and edited volumes.[7] While the work within these discursive mediums attempts to coalesce Islamic bioethics into an academic field with well-defined disciplinary parameters, the research methods, scope, content, and contours of the field remain obscure. One critically illustrative example is that many of scholars debate about the source of 'Islamic' content for Islamic bioethics. Some advocate for Islamic law to be the primary source of moral reasoning, while others suggest that there is no 'Islamic' version of bioethics at all.[8] Similarly, educators debate whether Islamic bioethics training should focus on teaching virtues or whether Islamic law coursework is requisite.[9] Furthermore, scholars differ regarding which concepts and frameworks bridge Islamic ethical frameworks with those used in the bioethics academy.[10] All in all, debates and unsettled questions continue to persist regarding both the

religious grounds of Islamic bioethical positions and the reasoning exercises needed to derive them. More significantly, patients and clinicians are often left with ethical guidelines that cannot be implemented in practice and thus some of their concerns remain unaddressed.[11]

Table 5.1: *A Typology of Islamic Bioethics Consumers and Their Needs*

CONSUMERS	MOTIVATIONS FOR SEEKING ISLAMIC BIOETHICAL GUIDANCE
Muslim patients and their surrogate decision-makers	• To establish concordance between clinical treatment courses and Islamic values
Muslim clinicians and their professional organizations	• To determine the ethical parameters of medical practice
Religious leaders, imams, and Muslim chaplains	• To ensure that the bioethical advice they give to patients, clinicians, and the Muslim laity is consistent with the Islamic moral tradition
Hospitals and healthcare systems	• To understand the needs of the Muslim patient population and provide religiously-sensitive healthcare
Health policymakers and legislators	• To design pluralistic and nuanced healthcare policy and law
Academicians and researchers	• To establish the pedagogical parameters for the field • To study, synthesize, develop, and critique the literature in the field
Islamic/Muslim bioethicists	• To inform their practice as ethics advisors on research and clinical ethics committees and on advisory councils • To inform their scholarship

Source: Adapted from Aasim I. Padela, "An Introduction to Islamic Bioethics: Its Producers and Consumers." Medicine and Shariah: A Dialogue in Islamic Bioethics, ed. Aasim I. Padela. (Notre Dame, IN: University of Notre Dame Press, 2021).

Given this general state of affairs, several prominent Muslim thinkers advocate approaches to Islamic bioethics based on the higher objectives of Islamic law. Different rationales are advanced for why frameworks built upon the *maqāṣid al-Sharīʿah* may better furnish Islamic medical ethics guidelines than fiqh and *adab* (virtue ethics-based) models.[12] These reasons largely mirror the contentions made about the *maqāṣid al-Sharīʿah* being more amenable to contemporary

Table 5.2: *A Typology of Islamic Bioethics Producers and Their Primary Roles and Outputs*

PRODUCERS	PRIMARY ROLES	PRIMARY OUTPUTS
Islamic jurists	• To serve Muslims by enabling their continued adherence to the faith	• Fatwas • Judicial opinions *qararāt*)
Muslim clinicians	• To serve as biomedical experts helping jurists understand the biomedical science and context surrounding bioethical questions • To serve as conduits of Islamic bioethical knowledge to patients who might ask for religiously informed opinions on medical treatments and decisions	• Peer-reviewed journal articles
Islamic and religious studies experts	• To study and address dialectics between Islam and bio-medicine by analyzing the literature and drawing on aspects of the Islamic intellectual tradition	• Normative essays • Books and book chapters • Peer-reviewed journal articles
Social scientists	• To describe how Muslims engage with bioethical questions and negotiate their values and identities in society	• Books • Peer-reviewed journal articles • Policy reports and briefs
Islamic/Muslim bioethicists	• To serve on clinical and research ethics committees, as well as bioethics advisory groups, offering Islamic and Muslim ethical insights • To advance scholarship in the field	• Books • Peer-reviewed journal articles • Normative essays
Muslim health professional organizations	• To convene scholars to deliberate about bioethical questions • To generate bioethics primers and policies	• Books • Articles • Judicial opinions (*qararāt*) • Primers
Juridical academies	• To bring jurists together to render Islamic ethico-legal opinions	• Books • Fatwas • Judicial opinions (*qararāt*)
State authorities	• To use Islamic ethics and law as sources in crafting policies and laws	• Policies • Laws

Source: Adapted from Padela, "An Introduction to Islamic Bioethics."

life, as noted in the previous chapters. To recap briefly, it is argued that *maqāṣid al-Sharīᶜah* frameworks better account for changing societal conditions and new scientific knowledge than traditional methods of deriving Islamic law.[13] It is also believed that *maqāṣid*-based ethical frameworks are more useful for practical decision-making because they are decoupled from scriptural hermeneutics and

advanced legal reasoning methods requiring specialist knowledge. Moreover, this feature makes the *maqāṣid* particularly useful in secular spaces where rational arguments hold sway. Finally, *maqāṣid*-based frameworks are thought to represent the 'spirit' of the Islamic revelation and, as such, are more appropriate grounds for bioethical deliberation than fiqh rulings.[14]

Accordingly, there is a small but growing body of literature on the interface of medical ethics and *maqāṣid al-Sharīᶜah*[15] and medical ethics training programs in the Muslim world have begun to incorporate teaching on the *maqāṣid*.[16] While several *maqāṣid al-Sharīᶜah*-based frameworks are being used for medical ethics deliberation, an analysis of these models remains wanting. This chapter fills in this gap in scholarship. I describe how leading thinkers such as Profs. Gamal Eldin Attia, Tariq Ramadan, and Omar Hasan Kasule build out *maqāṣid* frameworks for medical ethics by expanding upon Imam al-Shāṭibī's theory. I categorize these varied approaches into field-based redefinition, conceptual extension, and text-based postulation, and detail how each approach sets up a unique form of medical ethics deliberation.

The *Maqāṣid al-Sharīah* and Islamic Medical Ethics

In what follows, I describe three different ways in which al-Shāṭibī's theoretical model[17] has been expanded for use in medical ethics deliberation.[18] Notably, scholars' approaches to reformulating al-Shāṭibī's model did not consider biomedicine to be the primary dialectical partner.[19] Instead, the theorists attempted to design generalizable frameworks. Hence, the three approaches I describe below are broadly relevant and not field-specific.[20]

Approach 1: Field-Based Redefinition

The first approach (which I call the field-based redefinition

approach) is structured within al-Shāṭibī's overall framework but reimagines the five essential *maqāṣid* in light of contemporary healthcare. Prof. Omar Hasan Kasule, a medical scientist and leading proponent of this approach, holds the view that slightly redefining the traditional five essential *maqāṣid* provides for an all-encompassing "Islamic theory of [medical] ethics."[21] Consequently, "for a medical issue to be considered ethical, it must fulfill or not violate one or more of the five purposes (*maqāṣid*)."[22] This reimagined view of the five essential *maqāṣid* allows them to function as meta-level principles undergirding an Islamic medical ethics theory applicable to current-day clinical ethics issues.

In order to apply the *maqāṣid*, field-based redefinition theorists effect a kind of paradigm shift whereby they reconceive the human interests pertaining to the five higher objectives (religion (*dīn*), life (*nafs*), progeny (*naṣl*), wealth (*māl*), and intellect (*ʿaql*)) by grounding them in biomedical culture and knowledge. The moral objectives of medical treatment come to be the preservation of each of these biomedically redefined interests. Subsequently, the medical ethics model built upon field-based redefinition transforms health into the ultimate human interest and refashions *maqāṣid* into hierarchical ethical principles servicing health.

The biomedically informed reconceptualization of the interests and objectives proceeds as follows. The concept of *dīn* shifts from 'religion' to 'worship' (*ʿibadāt*), which comprises both prayer and righteous works.[23] Healthcare is envisaged to preserve this interest by "protecting and promoting good health so that the worshiper will have the energy" to pray and perform meritorious deeds.[24] Similarly, treating mental disorders assists in preserving *dīn* because "balanced mental health" is integral to prayer and creedal affirmation.[25] Human life (*nafs*) is preserved by preventing and treating disease, ensuring proper nutrition, and maintaining a high quality of life through other therapeutics. The interest of progeny (*naṣl*) is converted into procreative capacity. Consequently, healthcare must protect this value by

treating infertility and "making sure that children are well-cared for so that they grow into healthy adults who can bear children."[26] The human interest of intellect (ᶜ*aql*) is reformulated as mental health, and medical care preserves this interest by treating psychoses and drug addiction, and by effectively treating physical maladies that contribute to mental stress, Finally, wealth (*māl*) is redefined as societal wealth, and healthcare assists citizens to be financially productive by helping maintain sound bodies and minds.[27]

Although the "protection of life is the primary purpose of medicine," this model holds that healthcare intersects with all five essential interests.[28] Accordingly, in medical ethics deliberation a hierarchical order is maintained such that the preservation of worship takes precedence over all other interests, the preservation of human life comes second, and the preservation of procreative capacity, societal wealth, and mental health follow—with authors using different orders with respect to these three.[29] According to its proponents, this hierarchy "allows for the resolution of conflicting interests," as higher-order interests are privileged over lower-order ones during medical ethics deliberation.[30] Kasule terms this type of moral reasoning *ijtihād maqāṣidī* and popularizes the approach in medical school curricula around the Muslim world.[31]

Other prominent scholars support this approach generally with many introducing their own slight variations. Shaikh Mohd Saifuddeen, a scholar in the history and philosophy of science, is one notable advocate of field-based redefinition and its associated medical ethics deliberation model. Along with other colleagues, he writes that al-Shāṭibī's essential human interests must be "reinterpreted… in accordance with contemporary contexts" by considering contemporary harms and benefits within society and of healthcare technologies.[32] While he agrees with much of Kasule's redefinitions, he expands the notion of wealth to include intellectual property. Concerning the hierarchy among interests, he holds that the preservation of intellect ranks above the preservation of progeny and

property,[33] and protecting human life takes precedence over preserving religion.[34]

In Saifuddeen's model, moral evaluation of biotechnology involves multiple steps. First, the moral ends of biotechnology (i.e., the human interests biotechnology should serve) are determined by reinterpreting the five essential higher objectives of Islamic law "in accordance with contemporary contexts" so that knowledge from the biosciences is combined with scriptural knowledge.[35] Thereafter, moral assessment proceeds by evaluating whether the reasons the technology was developed, its procedural aspects, and the outcomes it produces "comply with Islamic teachings."[36] By 'compliance' the authors mean whether the technology maximizes the interests contained with the higher objectives, or at a minimum the benefits to be gained with respect to the interests outweigh any threats. This moral calculus is performed by preserving proposed hierarchies among the objectives and by accounting for the inclusiveness as well as the certainty with which certain interests are protected or threatened. Somewhat confusingly, the authors state that should a biotechnological application put *any* of the five essential interests at risk, it should be deemed impermissible from an Islamic standpoint, suggesting that the five interests are not truly hierarchical, rather they should instead be considered and/or treated as a group.[37]

Abul Fadl Mohsin Ebrahim, an Islamic studies expert and a thought leader in Islamic medical jurisprudence, also values this approach. For example, he states that the preservation of life (*nafs*) includes protection of health, and agrees with expanding intellect (*ᶜaql*) to include mental health.[38] Bouhedda Ghalia, another Islamic studies expert, takes a similar approach in transforming the preservation of *nafs* into the protection of the human body.[39] The field-based redefinition approach dominates *maqāṣid*-based medical ethics deliberation, as Muslim clinicians and ethicists apply it readily.[40]

A few examples will aid the reader understand how this framework applies to medical ethics decision-making. For instance, if one

spouse has AIDS and the other does not, it is judged permissible for the spouses to separate in order "to prevent the spread of infection" because preserving life is of higher priority than preserving procreative capacity.[41] At the same time, permanent sterilization is prohibited because it contradicts the preservation of procreative capacity, and using reproductive cloning violates the preservation of religion, for it disturbs God's natural order.[42] Concerning cosmetic surgery, it is considered valid "if carried out for beautification in order to find a marriage partner" because it advances the interest in procreation.[43] This type of reasoning is sufficient for medical ethics deliberation in Kasule's view, and is complementary, in Saifuddeen's view, to the four principle approach of Beauchamp and Childress.[44] According to Ebrahim the outcomes of such deliberation must align with *uṣūl al-fiqh*.[45]

In summary, field-based redefinition frames the human interests of religion, life, progeny, wealth, and intellect in light of biomedical understandings. As a framework for medical ethics deliberation, the essential *maqāṣid* become hierarchical principles. Accordingly, moral obligations and ethical practices are determined by evaluating how the proposed course of action advantages each human interest qua principle. According to some theorists, none of the essential interests can be violated for an action to be judged permitted and ethical; others suggest that the moral agent must justify departures from any of the principles by demonstrating that a higher-order principle is preserved. This practical, albeit elementary, distillation of the *maqāṣid* theory into a medical ethics framework is disseminated widely in the Muslim world.[46]

Approach 2: Conceptual Extension

Conceptual extension approaches involve a greater degree of departure from al-Shāṭibī's theory.[47] In contrast to field-based redefinition, where only the human interests are redefined, conceptual extension

involves revising further aspects of al-Shāṭibī's theory, adding new *maqāṣid*, and utilizing a different rubric for ethical deliberation. Each of these revisions is made to allow the incorporation of contemporary science into the theory and practical framework. Professors Gamal Eldin Attia, Tariq Ramadan, Jasser Auda, and Shaykh Yusuf al-Qaradawi all utilize conceptual extension to add new *maqāṣid*, although each offers a slightly different practical framework.[48] For the purposes of this book, I will describe Gamal Eldin Attia's and Tariq Ramadan's approaches, as both directly apply their frameworks to medical ethics.

As discussed in Chapter 2, Attia advocates for generating specific field-related *maqāṣid* and determining the best means to achieve them based on an understanding of the "divine laws of creation" and "definitive facts which have been identified by science" so that the ethical theory is "inclusive of all normative and objective elements" pertinent to the field.[49] He *conceptually extends* al-Shāṭibi's theory by (i) applying the concepts of essential, necessary, and enhancing to the means for achieving the *maqāṣid* rather than to the *maqāṣid* themselves and (ii) identifying new *maqāṣid* and reorganizing them within different domains.[50] According to his model, scientific data determines the means for achieving the *maqāṣid*. When a particular means brings about significant benefit or removes great harm, that means is classified as essential. Minor benefits or removal of minor harms through policy or action place that action or policy into the enhancing category, and necessary means fall between the essential and the enhancing ones.[51]

Attia holds that advances in human knowledge and changes in society necessitate discerning new objectives for Islamic law.[52] Hence his model contains 24 objectives across four domains: (i) the individual, (ii) the family, (iii) the Muslim community, and (iv) the level of general humanity. At the level of the individual, there are five essential *maqāṣid*: (i) the preservation of human life, (ii) consideration for the mind, (iii) the preservation of personal piety, (iv) the preservation

of honor, and (v) the preservation of material wealth. These essential interests are conceptually extended to include imperatives that emerge from science and society.

Attia's approach results in a number of expansions of traditional *maqāṣid* objectives and concepts. Contemporary views about "the right to life…[and] the sanctity of the body" is added to the objective of preserving human life.[53] The essential means for preserving human life involve: (i) protecting the body, (ii) maintaining life, and (iii) protecting against mortal harms. Consideration of the mind expands beyond the traditional view of preserving human intellect to require developing intellectual capacities and utilizing the mind in "intellectual acts of worship."[54] Attia refashions the preservation of religion into the preservation of personal piety, with its essential means including strengthening religious doctrines, performing the obligatory acts of worship, and focusing on moral formation. The preservation of honor refers to "anything related to human dignity," one's reputation, and the "sanctity of one's private life."[55] Material wealth is preserved through financial laws and penalties for theft. Additionally, Attia reformulates the preservation of progeny into the preservation of the human species along with other family-level objectives. Attia also revises al-Shāṭibī's hierarchy by noting that the preservation of material wealth has the lowest priority, with the preservation of "family lineage [or progeny], honor, and human reason" occupying a space above material wealth but below the preservation of human life.[56] He also appears to rank the preservation of human life over the preservation of religion because religious life is contingent upon being alive.

Commenting on how his model applies to healthcare, Attia argues that seeking and providing certain types of healthcare are moral duties. These ethical obligations emerge from the *maqṣad* of preserving life. Hence treating infectious diseases and radiation exposure is obligatory because they are "mortal dangers" that can eliminate human life universally.[57] Similarly, because physical integrity is

central to preserving life, there is an ethical obligation to build trauma systems and hospitals. With respect to reproductive health, Attia considers abortion and hysterectomy to be prohibited because they contradict the *maqṣad* of preserving the human species.

Following this pattern, Tariq Ramadan, a leading Islamic ethicist, also *conceptually extends* al-Shāṭibī's model. He also redefines old, and identifies new, human interests to be preserved and specifies different levels at which they operate. Like Attia, he finds al-Shāṭibī's *maqāṣid* focused on individuals and lacking attention to natural and social scientific data. He argues that an understanding of human interests "should be developed not only in the light of scriptural sources but also of contemporary knowledge and related ethical requirements."[58] Ramadan builds a model that integrates scriptural knowledge with the human sciences to yield a "theoretical and practical outline of an applied contemporary [Islamic] ethics."[59] Therefore, his extension involves identifying new higher objectives "on the basis of the two Books [revelation and nature]" and by "taking into account the evolution of our knowledge in the two fields of study [religious sciences and the sciences of the universe]."[60]

Ramadan's objectives operate at three levels: (i) the inner being, (ii) the individual and small groups, (iii) and society. In this way, his and Attia's models are alike. However, Ramadan innovates by placing a few governing *maqāṣid* upstream to these levels noting that they operate "even before getting down to the specification of human action."[61] In his view, there are two overarching objectives from which all Islamic laws, policies, and ethics issue forth: (i) "the protection of *dīn*" by which he means "a conception of life and death" according to Islamic theology, and the protection of "*al-maṣlaḥa*," which he defines as "the common good and interest of humankind and the universe." Underneath these are the three core ethical values of "respecting and protecting life (*hayāh*), nature (*khalq*), and peace (*salām*)."[62] These three objectives are 'a priori goals' for Islamic ethical frameworks. He next enumerates a final superstratum of values that

reside below these three objectives but precede *maqāṣid* at the individual, group, and societal levels. These are "promoting and protecting dignity (of humankind, living species and nature), welfare knowledge, creativity, autonomy, development, equality, freedom, justice, fraternity, love, solidarity, and diversity."[63] Detailing Ramadan's conceptions of these values is challenging as he does not elaborate on them in much detail; instead, he calls for religious scholars and experts from the sciences to work together to flesh out the concepts. Both camps of experts must also determine how the *maqāṣid* can be achieved and when they are at risk.[64] Nonetheless, he utilizes his work-in-progress model to generate medical ethics rulings.

Ramadan proposes that preserving the highest-order objective of "the Islamic conception of life and death and of people's common good and interest" is the overarching ethical mandate of an Islamic medical ethics framework.[65] This objective is the primary end-goal of healthcare from which second-order ethical duties emerge. The second-order *maqāṣid* are the preservation of life, of personal integrity, and of human dignity. He holds that these *maqāṣid* must be understood through an integrative reading of scripture and the health sciences.

As an illustration of this kind of reading and its application, he addresses the ethics of end-of-life healthcare. With respect to whether it is ethical for a physician to assist a patient in ending their life, he judges it forbidden because assisted suicide contradicts the highest-order objective: an Islamic understanding of life and death, and also contravenes the objective of preserving life. According to him, an Islamic understanding of life and death entails accepting that God decrees an individual's moment of death, and one should not take action to hasten it. This understanding also requires patients and physicians recognize that illness may serve a spiritually purifying function. At the same time, he holds that physicians are morally obligated to provide palliative care because it coheres with the *maqṣad*

of preserving human dignity. He also states that the preservation of dignity demands that patients and their families are free to choose "being kept alive mechanically," "to use all curative means available," or to "accept the decree of fate" when near the end of life.[66] This example illustrates how moral duties in healthcare emerge from trying to achieve and not contravene any of the objectives.

Beyond these two scholars, other ethicists utilize conceptual extension and apply it to biomedicine. For example, Nurdeng Deuraseh, a researcher, argues that protecting human health is one of the essential higher objectives of Islamic law. Relying on quotes from several Prophetic traditions that speak to the value of health as a blessing from God and as something to be grateful for and safeguard, he claims that worship "cannot be achieved without good health and well-being."[67] As such, the protection of health is an essential obligation. Another group of scholars subsequently utilizes this new objective to discuss neuroethics.[68]

In summary, the *conceptual extension* approach redefines the human interests contained within al-Shāṭibī's essential *maqāṣid* by drawing on contemporary social and scientific knowledge. It also identifies new *maqāṣid* by integrating scriptural sources and natural scientific data. The medical ethics framework that emerges from this approach is quasi-deontological, as moral obligations are derived by setting the *maqāṣid* as end-goals for healthcare delivery.

Approach 3: Text-Based Postulation

The text-based postulation method involves explicating a vision of human and societal flourishing embedded within al-Shāṭibī's essential *maqāṣid*. Thus the 'text' in text-based postulation refers to al-Shāṭibī's writings as the basis upon which one develops a moral vision for society.[69] This vision of life sets the base conditions demanded by Islamic morality. Once a clear vision is obtained, means (policies and actions) to achieve this vision are subsequently identified by drawing

upon natural and social scientific data. Hence this approach allows knowledge from the human, social, and natural sciences to specify how the *maqāṣid* are accomplished. Building upon these basic thresholds for human existence, secondary *maqāṣid* are determined via inductive readings of scripture or by recourse to human reasoning (this latter method also provides an entry point for scientific knowledge to help determining ethical actions). Accordingly, the necessary and enhancing objectives add additional ethical obligations propelling human life from an essential (minimal) level to a flourishing one.

Ethical frameworks emerging from this approach remain very close to al-Shāṭibi's theory. Indeed, it maintains al-Shāṭibī's hierarchy among the essential objectives and, as opposed to field-based redefinition, the human interests identified by al-Shāṭibi are also left as he defined them. Further, it differs from conceptual extension in that any new *maqāṣid* introduced must remain subordinate to the essential ones identified by al-Shāṭibi.

The text-based postulation strategy provides insight into the ends of healthcare and sets up ethical evaluation based on these postulated end goals. Recall that in Chapter 3, I described a vision of human health based on al-Shāṭibi's theory. It is that vision that sets up moral duties. Recall that al-Shāṭibī sets out three ways to actualize *ḥifẓ al-nafs*. First, procreation, which is the means by which life is produced, requires legitimating through laws that govern what relationships constitute a valid marriage and spell out what conditions must be met in order for a marriage contract to be valid. Second, preserving life equates to maintaining life, which requires providing food, drink, clothing, and shelter.[70] Third, the preservation of life entails criminalizing the taking of life.[71] Should these essential/minimal/base aspects of human health be protected, the corresponding state of living would result in the individual being minimally nourished and clothed, having their procreative capacity intact, and residing in a dwelling that offers protection from inclement weather. Societal and healthcare leaders would be morally obligated to furnish this base

level of living to humanity.[72] Current social and empirical knowledge will determine the actions and policies that bring about this minimalistic level of human living. While glimpses of this approach are seen in some writings, it has not been widely used in medical ethics.[73]

6

THE CRUCIBLE OF A "BRAIN-DEAD" PREGNANT WOMAN: DO MAQĀṢID FRAMEWORKS FOR MEDICAL ETHICS MEET THE CHALLENGE?

Applying *Maqāṣid al-Sharīah*-based Islamic Medical Ethics Frameworks

After discussing extant *maqāṣid*-derived theoretical models for Islamic medical ethics in Chapter 5, we can now move to the practical by evaluating the deliberative models and the answers they provide.[1] I will use the case of a woman declared "brain-dead"[2] at 19 weeks gestation to critically examine the merits and shortcomings of each of the three models. Our two ethical questions are: (i) what are the overall goals for patient care? and (ii) what are the ethical duties of two specific decision-makers, the attending physician and the patient's husband, toward her healthcare?

Before proceeding further, let me provide some medical and religious points of clarification. First, the current biomedical notion of brain death is a highly controversial one. From a biomedical perspective, scholars debate whether or not neurological criteria for death truly represent the irreversible cessation of brain activity, as well as whether these criteria accord with the loss of the integrative capacity of the human organism.[3] These and other issues contribute to significant debates in bioethics circles, with some calling brain death a fictitious status and others advocating for redefining criteria for death to make them more congruent with philosophical notions of human personhood.[4] In Muslim circles, Islamic jurists hold differing views as to what this state represents: some judge the state sufficient for declaring legal death in Islam; others recognize it as part of a dying process where a sort of unstable life is present; and another group accords a brain-dead individual the same status as a living person.[5]

Despite these biomedical and religious contentions, it is beyond dispute that a brain-dead patient can gestate an embryo and undergo labor when supported by biotechnology and hospital-based care.[6] The limits of fetal viability vary between 22 and 26 weeks of gestation, as different healthcare systems and legal jurisdictions set the minimum age of fetal viability based on their capacities for neonatal intensive care. Biomedical data on survival rates at different gestational stages suggests a rule of thumb for estimating fetal viability odds: approximately 25 percent of births at 23 weeks, 50 percent at 24 weeks, and 75 percent at 25 weeks of gestation survive hospital discharge in modern hospital systems.[7] From a religious standpoint, 19 weeks gestation is beyond the posited timing of the ensoulment of the fetus, which occurs, according to the two prevailing theological views,[8] at either 120 days or at 40 days of fetal age.[9] Hence, the fetus is not yet clinically viable but has a quasi-independent moral standing as a human being within the Islamic tradition.[10]

Solving the Case: Treatment Goals and Moral Duties Based on the Three Ethical Frameworks

Field-Based Redefinition Models

The first framework, field-based redefinition, results in a principlist approach to medical ethics deliberation. This means that all moral goals related to preserving religion, life, progeny, wealth, and intellect are considered in light of biomedical understandings of these terms. Taking Kasule's exposition as an exemplar, these five interests are transformed into worship, life, procreative capacity, societal wealth, and mental health with the moral imperative being to preserve and protect them. This approach requires determining how a particular course of action furthered such preservation and protection. If some interests are advanced and others breached, one must assess whether higher-order goals are preserved. An ethical act would

preserve all, or at a minimum, the higher-order interests at the cost of the lower-order ones.

Using Kasule's rubric as a guide, let us assess the ethical parameters of the case. First, the highest objective of preserving the capacity for worship is not possible for the mother. A brain death diagnosis represents an intensely depressed neurological state that cannot be reverted to a conscious state using available medical therapies.[11] Thus, the necessary cognitive status to pray and perform meritorious works is unattainable for her. The next highest-order objective is the preservation of life. With respect to this objective, the analysis hinges on whether the brain death state is analogized to a dead, dying, or fully living person. If the condition is not considered to represent a legally, metaphysically, or physiologically dead human being, then the preservation of life would be attained by keeping the patient on life-sustaining technology.[12] Third, the objective of maintaining procreative ability, this goal is furthered by keeping the patient on life support and eventually delivering a live child. The preservation of mental health objective is not relevant in our case because the patient will not regain a conscious state. Finally, concerning the preservation of societal wealth, the costs of intensive care for such a patient are incredibly high, typically thousands of dollars per day, and maintaining life support would drain the financial resources of the family and other responsible parties.

In summary, then, for the mother, two of the objectives do not apply (the preservation/protection of religion and mental health) due to her cognitive status. Of the remaining three, the preservation of life and procreative capacity is furthered by maintaining life support, while the preservation of societal wealth is disadvantaged. Given that the preservation of life and procreative capacity have higher priority than the preservation of societal wealth, the framework would suggest that life support and clinical treatment should continue as long as possible. Once the fetus is birthed, the goal of preserving procreative capacity is fulfilled leaving the preservation of life as the sole higher

objective that generates a moral obligation to continue life support. Whether or not a brain-dead person is alive is a contested question. Notably, if the mother were considered a dead person, the analysis would be similar because the preservation of procreative capacity would be furthered by maintaining her on life support until the fetus is delivered.

Additional support for such courses of action is found by analyzing the scenario from the fetus' standpoint. Taking this perspective, the living/dead status of the mother becomes moot and the possible ethical entanglements over lack of clarity about her status are mostly avoided. In other words, even if the mother were considered dead, preserving the fetus' life becomes possible by maintaining life support until delivery. The fetus' future capacity for worship, procreation, and intellection are all similarly advantaged, given that life is instrumental to obtaining these interests. Again, societal wealth would be threatened, but given its lower priority, the ethical end goal would be to maintain life support until fetal viability.

With respect to the ethical duties of the treating physician and the husband who serves as the surrogate decision-maker, they must work toward meeting the goals of care outlined above. The physician (and his/her team) are morally responsible for maintaining life support technologies and medical treatments to sustain the mother's life and gestational capacities. Additionally, they must apply therapies that will assist the fetal organs in maturing such that it is viable for delivery. Once the fetus is delivered, the duty to care for the mother may or may not continue depending on whether she is considered a living or dead person. The husband is similarly charged as his ethical duty to both his wife and potential child is to protect their lives. Hence, he has a duty to request that the treating physicians perform procedures and apply therapeutics that maintain the life of his wife and his future offspring.

Conceptual Extension Models

The conceptual extension models generate new *maqāṣid* as end-goals for healthcare. Recall that both Attia and Ramadan seek to incorporate scientific knowledge both into a revitalized conceptualization of human interests as well as in the identification of means by which these are preserved. As such, biomedical knowledge should theoretically inform the ethical objectives and how they are accomplished. Attia considers preserving human life to be the most important ethical imperative and designates it to include a right to life and preserving bodily sanctity. In our scenario, setting this as the end goal of healthcare would suggest that the mother's life and the sanctity of her body should be maintained.[13] Among the other essential human interests and accompanying objectives (namely consideration of the mind, personal piety, honor, and material wealth), the only one that applies in our scenario is material wealth. As with the previous analysis, preserving human life in our present scenario would entail sacrificing material wealth; however, given human life is more important than wealth, the preservation of life would be privileged.

The challenge, however, is that in the case of providing life support to our brain-dead patient, the two components of the objective of preserving life are at odds with each other, namely the right to life and the sanctity of the body. Suppose one believes that the brain-dead patient is alive. In this case, maximizing her right to life requires violating her bodily sanctity by supporting her breathing via invasive mechanical ventilation as well as disrupting the integrity of the body by means of catheters that collect urine, tubes that provide nourishment through the alimentary canal, and intravenous tubing that provides medications and fluids as needed. Clinical science and biomedical research would support these medical interventions as necessary to maintain bodily functions in a brain-dead state. In other words, Attia's model would declare these to be necessary means backed by scientific data.

Considering the perspective of the fetus, a similar conflict arises. As an ensouled being, the fetus also has a right to life, and its life should be preserved. However, to preserve its life, the bodily sanctity of the mother must be violated, for she would need to be maintained on maximal life support and be given medications for the fetus to be successfully gestated and delivered. This action would lead to a series of increasingly complicated ethical questions that are not likely to be easily answered. For example, does the mother's brain-dead status somehow affect the 'value' of her life, making the life of the fetus more worth saving at the expense of her dignity/sanctity? How do we weigh the potential beneficial outcome of the fetus surviving and living long enough to attain the interests of him/herself against the actual outcome of harming the mother's bodily sanctity? These sorts of questions illustrate frameworks that probe deeper than the *maqāṣid*-based conceptual extension framework are likely needed.

Overall, given that one aspect of the end goal conflicts with another, setting the preservation of human life and its components of a right to life and bodily sanctity as the overarching end goal for healthcare does not provide precise insight into the most ethical course of action. One possible solution would be to declare the mother dead and accept the violation of the sanctity of a dead body to maximize the fetus's right to life.[14] Alternatively, one could consider the physiological functions of a brain-dead patient to be sufficient markers of human life and preserve her life at the cost of her bodily sanctity. The most prudent course of action may be to maintain the pregnant woman's life and accept the many clinical interventions and accompanying costs required to do so. In this way, the most important part of the objective is met and both her and the fetus's lives are protected.

At the same time, ethical deliberation over the meaning of brain death appears necessary, and on this question, Attia's theory would defer to the social and natural sciences. Unfortunately, controversies abound since death is a social construct that brings together purposes,

criteria, and behaviors and the ontological reality of death cannot be resolved from social and natural science data.[15] It follows from the preceding analysis that the ethical duties of the treating physician and the husband would be to maintain life support.

Ramadan considers the highest order objectives to be: (i) preserving an Islamic conception of life and death; and (ii) seeking the common good and interests of humankind.[16] These overarching *maqāṣid* are supported by numerous ethical duties related to promoting life, nature, and peace. Taking this framework as a starting point for ethical deliberation, we run into similar troubles to those we closed with in the previous section. What is an 'Islamic' conception of life and death? And how is it to be preserved? Ramadan would seek answers from scripture and science here, but both knowledge domains lead to ambiguous answers. From a scriptural perspective, while a metaphysical definition of human death as the departure of the human soul from the body is doctrinal, the physical markers of such are not definitive. Both classical and contemporary Islamic theologians debate the nature of the soul and how its functions manifest in the body.[17] They also debate when ensoulment of the human body occurs as this subject is particularly relevant to questions of abortion.[18] And with respect to the signs of death in the body, many scholars assert that the signs noted in legal manuals are either based on custom or expert testimony; in other words, they are not scripturally grounded.[19] Indeed, the view that markers of death need not be scripturally sourced allowed for accepting neurological criteria for death as sufficient markers for legal death in Islam.[20] Hence, there is no uniformly shared or agreed upon scripturally grounded conception of life and death as it relates to ensoulment and bodily manifestations in Islam.

Ramadan may seek answers from natural theology and biomedical science, but these do not offer clarity. Again, the brain-dead patient is "betwixt and between" traditional notions of life and death and challenges religious and biomedical constructs on both ends.[21] A moral

end for healthcare that protects Islamic conceptions of life and death is out of reach. Indeed, scholars argue that human death is a social construct[22] and the biological criteria for life are not as definitive as they may seem.[23]

Looking to the other overarching objective of promoting humankind's common good and interest does not suggest a clear end goal either. Does society benefit from, or is it harmed by, maintaining a pregnant brain-dead woman on life support? Arguments could be made either way, as there is undoubtedly a cost to bear for such maintenance, yet adding a citizen to society can yield fiscal benefit. Economic analysis may suggest maintaining the patient until fetal viability and then withdrawing life support. But there are social costs of doing so; how would families feel when their loved one's life is reduced to that of an incubator? How would clinicians and nurses feel when asked to apply maximal life support to what the law would suggest is a corpse? Hence, this other overarching objective does not provide a clear answer either. Accordingly, the physician and husband's ethical duties remain unclear.

Text-Based Postulation Models

In the case of text-based postulation models medical ethics deliberation would require an explication of a moral vision for healthcare based primarily on al-Shāṭibī's essential *maqāṣid*. This vision would be supported by secondary objectives and means identified by science. As detailed in Chapter 3, al-Shāṭibī's *ḥifẓ al-nafs* sets up a vision of health that is minimalistic. The base level of human health sets as an ethical requirement that an individual is minimally nourished and clothed, has his/her procreative capacity intact, and resides in a dwelling that offers protection from inclement weather. With this vision as an end goal, Islamic medical ethics stakeholders would be morally obligated to develop healthcare systems that address these social and physical determinants of health.[24] In our case scenario, if we

consider her to be alive this base level of living can be attained for the mother in the hospital. Intravenous and/or alimentary nutrition can be provided, the patient can be clothed, and hospitals are structurally intact enough to protect her from inclement weather. Beyond this, other moral duties may be added based on biomedical knowledge. For example, providing supportive care to keep the patient infection-free, well-groomed, and the like would be considered secondary moral duties that complement and support life preservation.

On the other hand, if she were judged to be a dead person, the fetus's perspective may be considered. Preservation of its life demands a similar state of living as the mother, and meeting the minimal requirements essential for this can only be achieved by maintaining the mother on maximal life support. Accordingly, both the physician's and husband's ethical duties are to maintain life support and ancillary treatments for the mother (and thereby for the fetus). The physician should provide them and if not the husband should request they be provided.

Shortcomings of the *Maqāṣid*-based Medical Ethics Frameworks

Intrinsic Ambiguities

All three frameworks advance keeping the mother on maximal life support based on various configurations of the higher objective of preserving life. To review, Kasule's field-based redefinition model suggests that the costs associated with this course of action disadvantages preserving societal wealth yet furthers preserving the higher objective procreative capacity. Overall, the action is justified and morally obligatory. Attia's conceptual extension model combines moral duties to preserve bodily sanctity with the preservation of life and his model's suggested course of action creates internal conflicts within this singular end goal for healthcare. Despite these conflicts, the course of action appears to be justified. On the other hand,

Ramadan's conceptual extension model is ambiguous about end goals. Finally, the text-based postulation model also sanctions maintenance of life support as this fulfills the minimal vision of health obligated by the *maqṣad*. The preservation of progeny is also advantaged. In short, these *maqāṣid*-based versions for medical ethics deliberation would require healthcare stakeholders to do all they can to maintain the mother's life.

Yet, these answers reveal shortcomings in the frameworks. From a practical standpoint, none of the proposed rubrics and frameworks provide insight into the limits of this obligation. While al-Shāṭibī's theory considers the preservation of religion to be of higher priority than the preservation of life, that notion provides no practical guidance to the text-based postulation model employed to address the case scenario. It does not offer insights into whether the mother's life should be considered of lesser value than the potential life of the fetus because the fetus holds the potential for future religious practice while the mother does not. Knowing whether to prioritize clinical treatments for the fetus over those for the mother is important for instituting a clinical care pathway. Perhaps the rubric is not intended to offer such guidance; and if this is the case, then the answers resulting from applying this model for medical ethics deliberation may yield only partial answers. Thus, supplemental methods may be needed to delineate end goals for clinical care clearly.

The proposed hierarchies are intended to address conflicts between principles, but without limitations is that possible? The hypothetical case brings up an issue endemic to al-Shāṭibī's theory. In his view, the interest of religion ranks above life, and therefore moral duties to preserve religion supersede obligations related to preserving life. The posited field-specific redefinition frameworks revise this hierarchy while introducing ethical conflict. For example, in our case, the physician's moral obligation is to continue to apply advanced technology to maintain the patient's life even in a severely compromised neurological state where worship is not possible and

financial costs are high. In this scenario, preserving religion is not possible and preserving societal wealth is threatened, yet the moral duty to preserve life appears to supersede all other concerns. Even if the patient is judged to be dead, preserving the procreative capacity of the mother and/or the preservation of the fetus's life may demand maintaining life support.

Ramadan refashions the preservation of religion into duties to preserve Islamic conceptions of life and death, but as mentioned above, there is little conceptual clarity about what this ethical imperative entails. The other models obligate the preservation of life seemingly at all costs. A real-world application would introduce many different constraints to such a moral obligation. Beyond fiscal constraints, many localities, including Muslim jurisdictions, consider brain death to be a legally dead state despite the many clinical and ethical controversies it entails.[25] Muslims trying to live out an Islamic ethical vision based on these *maqāṣid* would have either to find legal recourses to maintain the patient on life support, or, alternatively, accept their inability to live out Islamic ideals due to contextual constraints. The theorists elaborate no limits on preserving life. However, a framework without constraints is not only impractical it also fails to acknowledge actual limitations on human actions, leaving the moral guidance moot.

Additionally, the human costs of such maintenance are not accounted for in any of the three models. Social scientific research finds that individuals suffer considerable emotional stress when loved ones are in the intensive care unit. Long-term support of individuals without hope for meaningful recovery can also lead to familial discord and disruption of caregiver's life plans.[26]

My point here is not that withdrawal of life support is the most ethical course of action, but rather that medical ethics deliberation based on the *maqāṣid* is posited to better account for empirical and social scientific data. In our scenario, it is not clear how these data are 'better' accounted for.

Moving from practical to conceptual issues, none of the frameworks nor their underlying theories provide adequate resources to address the thorny question of brain death. One would imagine that theories built around the imperatives of preserving intellect and preserving life should be suited to address this question, especially considering that this is where the tension between the two imperatives occurs. But, as of yet, this issue remains unaddressed. The question of brain death is part of a larger conceptual problem for *maqāṣid*-based approaches to resolve and attain an effective degree of clarity on. Indeed, at the conceptual level, what is entailed by the interest of human life needs greater exposition so that it can be preserved; a better conceptualization of life would allow for a better conceptualization of its absence, that is, death. Since these are the two poles between which medical care operates, it is vital that *maqāṣid*-based approaches to medical ethics deliberation detail, as precisely and concretely as possible, what human life and death are.

With Respect to Fiqh

When compared to extant fiqh rulings, other concerns crop up. Islamic jurists have debated the acceptability of neurological criteria for death declaration in Islam for decades.[27] While proponents and detractors exist, there is a zone of near consensus and an operative plurality on the issue. Several international Islamic juridical councils have judged it legally permissible to withdraw life support when brain death is declared, basing their views by either deferring to medical authorities, by legitimating the scientific basis for death declaration, or by drawing upon classical rulings that consider medical care to be non-obligatory.[28] Even scholars who hold that brain death falls short of Islamic legal standards of death condone withdrawing life support when such a state is reached, though they suggest that death should be declared when the heart stops irreversibly.[29] Hence, the near-consensus view is that life support can be withdrawn.

The *maqāṣid*-based medical ethics models would seemingly contradict these fiqh-based rulings and this incongruity may lead to hesitance or confusion among various Muslim stakeholders.[30] At a minimum, the *maqāṣid*-based analyses reveal that the general ruling is not applicable in this scenario. Similarly, *maqāṣid*-derived notions of preserving life at all costs seem to counter the ethical notions embedded within the four Sunni schools of the non-obligatory nature of medical treatment except for when the treatment is assuredly life-saving for *the patient*.[31]

While departures from established fiqh may be justified, and even commendable given that *maqāṣid*-based analyses are supposed to overcome the limitations of fiqh, the dissonance may give pause to local imams and Muslim chaplains counseling Muslim patients and providers. These advisors may be feel uncomfortable with perceived discrepancies between established fiqh rulings and *maqāṣid*-based answers. Muslim bioethicists may similarly desire greater substantiation before implementing the proffered ethico-legal guidance. The theorists advancing *maqāṣid*-based approaches to medical ethics should acknowledge these needs by delineating whether, and if so how, fiqh-based rulings and *maqāṣid*-based analyses should be aligned.

Returning to the question of practical limits, some scriptural notions of human dignity also place constraints on the maintenance of life support. These notions are accounted for in fiqh rulings but seem to be missing in the extant *maqāṣid* approaches. Every clinical therapy disturbs the inviolability (*ḥurma*) and sanctity (*karāma*) of the human body. Hence, jurists argue that these violations are only acceptable when treatment efficacy is high (e.g., surgery for appendicitis) and when a positive outcome is expected. However, when there are no viable 'good' outcomes, these violations should constrain clinical interventions. Given the interminable march of a patient diagnosed as brain-dead toward cardiopulmonary collapse and the current impossibility of recovery to a consciousness state, one

may argue that the disruption of *ḥurma* and *karāma* tilt the equation toward the withdrawal of life support.[32] The *maqāṣid* models appear not to account for such concerns. Even when notions of bodily sanctity and human dignity are incorporated within frameworks, these human interests are subordinated.[33] So much so that if the patient is judged to be a dead human,[34] the preservation of progeny supports maintaining life support despite threats to human sanctity and inviolability. This idea of instrumentalizing the mother's life to facilitate the fetus' seems without precedent. Although the dead body can be violated to achieve justice by retrieving lost property, for example, and a nearly dead pregnant woman can be dissected to save the fetus,[35] our case involves using the mother's body as an incubator for several weeks until the fetus is viable and thus represents a prolonged period of disruption to bodily sanctity. Although proponents argue that *maqāṣid*-based models for ethico-legal deliberation reflect the spirit of the law, the ways in which the aforementioned medical ethics models are seemingly misaligned with extant rulings call for caution. Opting for *maqāṣid*-based reasoning to the exclusion of fiqh methods in Islamic medical ethics deliberation may be ill-advised.

Issues of Method and Utility

Beyond the practical and conceptual, *maqāṣid*-based approaches to biomedicine also pose methodological problems. A field-based redefinition approach transforms health into the ultimate human interest and refashions *maqāṣid* into hierarchical ethical principles servicing health. This approach can fall prey to relativism. Since the core human interests—religion (*dīn*), life (*nafs*), progeny (*naṣl*), wealth (*māl*), and intellect (*ᶜaql*)—are defined according to public understandings, these definitions may vary from culture to culture, as well as across time. Such relativism undermines the argument that the *maqāṣid* frameworks speak to universal moral norms. Indeed, Beauchamp and Childress's widely utilized four-principle medical

ethics model is critiqued for much the same reason.[36] Assuredly, human interpretation of principles introduces plasticity that can help the framework adapt to different times and contexts. Yet, by removing the scriptural anchor that stabilizes the definitions of religion, life, progeny, wealth, and intellect, the concepts become susceptible to widespread variability and may be redefined almost at a whim. Illustratively, traditional views conceive of the human interest of *māl* as personal physical property. Kasule, however, redefines the essential interest of *māl* as societal wealth and Saifuddeen includes intellectual property in his vision for this human interest. With scholars and practitioners defining the interest differently based on field-specific understandings, a cohesive and uniform Islamic moral vision for society seems impossible. Moreover, the posited Islamic nature of the bioethical theory becomes somewhat suspect when the human interests and the ethical duties that surround them are no longer rooted in revelation.

Finally, there are gaps within the *maqāṣid* models that may limit their utility. The theorists do not consider the necessary and the enhancing objectives of Islamic law. They neither enumerate them nor identify a role for such secondary objectives within their version of Islamic medical ethics deliberation. In al-Shāṭibī's theory, these secondary objectives support the essential objectives and allow the framework to evolve based on knowledge from contemporary natural and social sciences. Given the conspicuous absence of these subsidiary objectives, one wonders how such medical ethics frameworks would stand the test of time to adjudicate matters that lie outside of the five essential *maqāṣid*. Moreover, it is unclear how the model would advance the social and political conditions needed to live out the essential objectives.

The conceptual extension approach identifies new means to achieve the classical essential *maqāṣid* by drawing upon contemporary knowledge, and it identifies new *maqāṣid* grounded in scripture and in science. This version of a medical ethics framework sets moral

duties cohering with these *maqāṣid*. The principal challenge for such a framework is understanding the Lawgiver's intent and thereby ascertaining the normative order of things. Ramadan ascribes normative value to nature such that it stands alongside scripture as the foundation for objectives and their concomitant moral duties. Attia values natural and social scientific understandings. For medical ethics deliberation, the challenge is harmonizing these multiple understandings to define the normative body and its telos.

For example, if one were to look to nature to understand the value of reproductive organs, one may suggest that they exist for procreation. At the same time, the Qur'an relates that God creates some individuals infertile. How would one determine an Islamic bioethical perspective on fertility treatment in light of these two sources of guidance? Some may term infertility a disease that obligates remedy, while others may consider the lack of offspring to require acceptance of divine decree. Would an Islamically oriented healthcare system be obligated to research and fund therapies that restore function to a patient's reproductive organs?

Similarly, the issue of brain death exemplifies that biomedical understandings and data may not yield the desired result. Instead, a normative fallacy arises: biology and science may describe reality and generate facts but cannot provide the moral value inherent in such things. The values ascribed to realities and facts must come from elsewhere. Previously, scriptural hermeneutics would be utilized to ascribe values. However, the conceptual extension approaches do not detail how to do so. These theories do not describe the parameters under which scientific facts inform the conceptualization of human interests. In other words, since reality and scripture both inform our understanding of the human interests to be preserved and the means to achieve such preservation, is there privileging of one over the other?

A medical ethics schema based on text-based postulation would operate within, and be confined to, the conceptual framework and

definitions of al-Shāṭibī's complement of essential human interests, which he based on an inductive reading of scripture in the fourteenth century. The danger with this approach is one of incongruity or anachronism: it does not account for the evolution of human knowledge and societies after his time. In other words, al-Shāṭibī's *maqāṣid* theory has remained static while culture and science have undergone dynamic changes. The fixation on retaining al-Shāṭibī's original definitions effectively precludes a redefinition of the essential *maqāṣid* and thus the theory is not easily adapted to advancements in human knowledge and technical capacities.

To illustrate this challenge, consider medicine's ability to intervene in disease. Today such technical capabilities are vastly greater than in the fourteenth century when al-Shāṭibī was detailing the moral duties of preserving human life. How would one update the model to reflect this? Contemporary scholars may suggest that the provision of healthcare, à la Attia, is part and parcel of the essential *maqāṣid* of preserving life because human existence depends on being free of fatal diseases. While text-based postulation might consider such provision to be a necessary means of preserving life, it will not judge this means to be an essential one: therefore, having a specific type of healthcare system is not morally obligated unless there is clear evidence that not having such a system in place is an existential problem. Hence, this medical ethics framework does not easily allow for broadening the essential *maqāṣid* and limits its flexibility across time and space.

The practical ethics challenges, conceptual ambiguities, and other shortcomings of the *maqāṣid*-based medical ethics frameworks may be explained by their status: by their very nature they are *works-in-progress*. Muslim thinkers concede that their *maqāṣid* theories and ethical frameworks require further development as they come to be applied in various disciplines and fields. With this concession in mind, I sought to pinpoint gaps and challenges so as to motivate further development of *maqāṣid*-based approaches to Islamic medical ethics.

In my view, in order to construct an Islamic medical ethics model based on the *maqāṣid al-Sharīʿah*, the following four methodological processes need to be detailed with precision: (i) how to identify *maqāṣid* relevant to bioethics; (ii) how to apply the *maqāṣid* by specifying them to a given case; (iii) how to balance *maqāṣid* in cases where one or more conflict; and (iv) how to adapt the *maqāṣid* for use in different societies.

A Different Role for *Maqāṣid* in Islamic Bioethics Deliberation

Maqāṣid-based medical ethics models are introduced into the broader Islamic bioethics discourse for reasons of pragmatism and posited utility. Advocates champion these tools as delivering the spirit of Islamic morality without the burden of requiring specialist knowledge of fiqh and scriptural hermeneutics to make moral judgments. Consequently, *maqāṣid* models are seen as instruments for rebalancing Islamic bioethical discourses by centering them round healthcare practitioners instead of jurists. Further, advocates claim these tools are not weighed down by historical social constructs and thus they can be rooted in the reasoning exercises of healthcare stakeholders rather than being anchored to outdated fatwas and societal considerations. While the models may furnish ethical principles rooted in the Islamic moral tradition, the frameworks appear replete with conceptual, methodological, and practical shortcomings.

Beyond these problems, using *maqāṣid al-Sharīʿah* theories and frameworks to adjudicate ethical duties and propose treatment plans at the bedside may be inappropriate because of their original interconnectedness with fiqh. The *maqāṣid* encompass human interests that the Lawgiver deems are worthy of preserving through fiqh. Classical theorists sought to complement fiqh and reorient rulings developed by expert legists by introducing the theories of *maqāṣid al-Sharīʿah*. However, by supplanting fiqh and scholars of fiqh, contemporary thinkers have replaced the time-tested reasoning exercises

and sophisticated ethico-legal concepts of fiqh with ones that are much less honed and cogent.

Instead, a more appropriate usage of the *maqāṣid* would be to treat them as ethical end-goals that should be maximized by social systems, including legal ones. Both classical theorists and contemporary thinkers agree that fiqh exercises have become too focused on the permissibility of singular acts and that legists sometimes use strained logic to resolve the concerns of individual Muslims. Both groups argue that a broader vision of the Lawgiver's purposes is needed to refocus the generation of fiqh and fatwas. Instead of using the *maqāṣid* for building frameworks for medical ethics deliberation and determining the ethics of an act, they should be utilized as a reading grid through which scholars determine which rulings best serve the ethical end-goals of Islam. Said another way, *maqāṣid*-based analyses could provide a quasi-sorting or controlling function by helping decision-makers select the best course of action among the various courses of action deemed permissible by fiqh.

As an aside, another argument for *maqāṣid*-based medical ethics frameworks is based on the idea that Muslim clinicians need a working knowledge of Islamic morality to live out Islamic ideals in medical practice. Therefore, *maqāṣid*-based frameworks are better suited for quick uptake and easy understanding. Unfortunately, the lack of constraints and balancing mechanisms within *maqāṣid*-based ethical frameworks, as well as their conceptual ambiguity, make them poor substitutes for secular medical ethics frameworks that draw on robust principle- and virtue-based theories. In my view, the Islamic legal tradition already contains a genre of pithy and robust ethical concepts (the *qawāʿid al-fiqhīyya*) that can be quickly understood by non-legal specialists and serve as foundations for ethical thinking. Moreover, this genre also has built-in balancing and constraining tools (*ḍawābit*) which would help prevent clinicians from utilizing the ethico-legal maxims inappropriately. This genre is much more suited for Islamic medical ethics training.

Certainly, *maqāṣid*-based approaches can help tie different strands of Islamic ethical reflection together to furnish a comprehensive and compelling Islamic bioethical theory. While Islamic law focuses on the moral significance of acts and Islamic virtue ethics addresses the moral formation of the agent, I contend that *maqāṣid*-based ethical frameworks should delineate end-goals and bring holism to the field. Since the *maqāṣid* reflect the divine intents related to human welfare, *maqāṣid* bioethical frameworks provide insight into what the Lawgiver intends for humanity to work toward: they can describe a vision of human flourishing that humankind should aim for. Indeed, if included with these other two disciplines, the new triumvirate would thus cover act-morality, agent-morality, and end-goal morality. Metaphorically, the *maqāṣid* would clarify the destination to be reached, fiqh would map out the multiple ways of getting there, and inculcated Islamic virtues would assure that one has enough fortitude to undertake the journey. Obviously, for the *maqāṣid* to illuminate the moral goals, they must be unambiguous, robustly conceptualized, and closely connected to scripture. Further development in *maqāṣid* theories and frameworks is required for this task. Finally, Muslim thinkers advocating for *maqāṣid* thinking in medicine have focused on inserting these frameworks into medical ethics. They hope that by reforming ethical deliberation, modern healthcare delivery will move closer into alignment with Islamic morality. Indeed, as seen in Chapter 1, contemporary healthcare is delivered as part of a cultural system containing ontological, philosophical, epistemic, ethical, and social commitments. The idea of gaining a toehold within the clinical ethics realm and then moving outward to systematically reform the entire healthcare system is laudable. Yet, the domain of ethics may be a starting point that is too far downstream to effect change for the way in which contemporary healthcare is set up prefigures certain types of ethical concerns and leads to specific conflicts among its various stakeholders. Injecting Islamic moral values to resolve a conflict at the bedside between two available courses of action does not necessarily

open up different courses of action. Said another way, Islamic moral frameworks may help clinicians and patients determine which of the *available* courses of action are more in line with the tradition, but reforming medical ethics deliberation at the bedside may not introduce *new* courses of action nor *change* the available options.

That sort of larger-scale reformation requires a multi-level approach by which the Islamic moral tradition engages with contemporary biomedicine. Ultimately, Islamic scholars must draw upon multiple Islamic sciences related to morality, not just the *maqāṣid*, to appropriately capture a multi-level Islamic moral vision. In so doing they will also need to closely analyze the cultural and philological-lexical aspects of juridical heritage to construct a repository of principles and rules that can be of service to Muslim stakeholders confronting bioethical challenges in contemporary healthcare. Such a project can go a long way in assisting Muslims to engage with biomedical faithfully.

The preceding chapters lay the foundations for such an intellectual project; Chapter 3 identified starting points of such reformation by delineating Islamic visions for human health; Chapter 4 outlined an Islamically sourced rubric for health policy development; Chapter 5 and this chapter, in turn, focused on Islamically grounded mechanisms for medical ethics deliberation. In the next chapter, I will describe how *maqāṣid* frameworks may inform the philosophy and practice of healthcare.

Before turning the page, however, let me underscore that the *maqāṣid* cannot do the job alone. Related to developing the field of Islamic bioethics,[37] in addition to further building up *maqāṣid*-based frameworks and bringing these into conversation with fiqh analysis and *adab* considerations, Islamic bioethics deliberation requires multidisciplinary insights into the ethical problem space. Traditionally, bioethical questions were addressed on a case-by-case basis through the medium of fatwa.[38] Determinations of medical fiqh, so to speak, stood in for Islamic bioethical deliberation and theorization. As the

questions came to involve policy dimensions, complex biomedical technologies, and the nuances of clinical practice, both the solicitor and the respondent may have reached out to external experts for input. This ad hoc process has crystallized, more or less, into what is now termed collective ijtihad. Collective ijtihad refers to a group of Islamic jurists jointly rendering an ethico-legal ruling after solicitation of input from diverse disciplines. The operational structure of collective ijtihad emerged from concerns that individual jurists were no longer expert in all of the relevant religious and scientific disciplines needed for morally evaluating modern technologies and social structures. Hence, bringing multiple religious scholars together lends rigor and strength to rulings by reducing the impact of individual jurists' cognitive biases and gaps in knowledge, and by providing different perspectives on how to utilize scriptural evidence for resolving the ethical problem. Simultaneously, the addition of varied disciplinary experts facilitates better mapping out the problem space for relevant lived experiences and disciplinary insights are furnished to the jurists.

In collective ijtihad related to bioethical issues physicians are often brought in by jurists to help clarify practice concerns, define the biological understandings, and offer up and interpret clinical data. At times, clinicians may offer their own 'Islamic' ethical opinions, though this normative role is highly controversial.[39] As I have commented elsewhere,[40] attending to the biomedical, social and political features of a given issue necessitates expanding beyond clinicians and jurists to bring social scientists and others with relevant expertise into the circles of collective ijtihad. These scholars can help frame the question at hand, comment on societal debates concerning the topic, opine on how courts and policymakers may read a potential fatwa, and provide insight into the social and practical implications of a particular fatwa. Such insights are essential to fully conceptualizing the ethical problem at hand, and accurate conceptualization is integral to *fatwa* making.[41]

Indeed my conceptual model for multidisciplinary Islamic bioethics deliberation involves scholars of clinical practice and health policy providing insider knowledge into why the ethical question emerges and informing jurists as to the ramifications of proposed ethico-legal opinions, and engages social and biomedical scientists as well as moral philosophers and bioethicists as critical interlocutors who help clarify the ethical values and social issues at hand while also pushing jurists to explain their reasoning processes so that an Islamic moral vision is better explicated.[42] In this way, multidisciplinary yields a more holistic analysis and, hopefully, leads to better solutions.

Additionally, addressing bioethical questions demands multi-level analysis. In scoping out the problem space, it is important to recognize that bedside concerns may be intimately connected to healthcare system challenges or to state health policies. For example, a bedside decision to apply or withhold ventilators is not only a question of ethical practice, it is intimately linked to questions about resource allocation of the existing supply of ventilators in the healthcare system, which, in turn, is connected to societal policies governing device testing and manufacture as well as supply chains. While this example suggests a unidirectional upstream and downstream flow, in other words, 'higher-level' societal decisions impact local challenges at the bedside, the reality is more complex with multidirectional relationships across tiers. Consequently, appropriately addressing bioethical questions may, at times, call for multi-level analyses.[43] With that said, let us now turn to the possible influence *maqāṣid* models may have upon the philosophy of healthcare delivery.

7

PRESERVING LIFE OR PRESERVING RELIGION? THE HIGHEST OBJECTIVE IN HEALTHCARE

Thus far, our exploration of the interface between the *maqāṣid al-Sharīʿah* and biomedicine has entailed conceptualizing human health (Chapter 3), considering how to structure society such that health-related dimensions of the *maqāṣid* can be realized (Chapter 4), and contemplating how the ethical values embedded within the *maqāṣid* may inform medical decision-making (Chapters 5 and 6). Accordingly, we have moved from theoretical issues to areas of more practical concern. This chapter, however, straddles both the theoretical and the practical to engender a vision of how the *maqāṣid* may shape a philosophy of healthcare.

Specifically, it will consider whether the preservation of religion or the preservation of life should be the highest-order moral objective of healthcare delivery. Posing such a question may seem counter-intuitive. Healthcare is obviously aimed at promoting and restoring health, and health cannot be had without life. It thus follows that the preservation of human life must be the highest objective of healthcare delivery. I do not wholly reject this idea nor aim to assert that Islamic morality would object to such a moral vision. Rather, there is more to the question of what higher objective should be given primacy when designing healthcare systems than meets the eye. Consider that there may be scenarios in which advancing religious dimensions of health may require sacrificing a portion of physical or mental health, as in the case of adhering to religious proscriptions against organ donation and transplantation, or even the simple practice of Ramadan fasting, which may require medication adjustment. A healthcare system that acknowledges the preservation of religion as a primary moral objective may develop practices and ethical guidelines

that attend to these scenarios differently than a system whose primary goal is the preservation of life. After a theoretical discussion about the value of life and religion, this chapter will reflect on what sorts of healthcare system features and practice elements follow from the preservation of religion. Minimal attention is given to describing what healthcare systems that grow out of the primary mandate to preserve life look like, because, more or less, that is what drives biomedically oriented healthcare systems today. Additionally, as noted in preceding chapters, one could argue that the higher objective of preserving human life extends to considerations about the afterlife and thus must align with goals emerging from the preservation of religion. In other words, there can be no conflict between duties emerging from these higher objectives. While I am uncertain that the subsuming is apropos, I readily admit that there is more consonance than conflict in healthcare between the goals of preserving religion and life. Yet a philosophy of care anchored in one or the other higher objective would provide a vision of how consonance is to be accomplished as well as how conflict is to be managed. This chapter will sketch out aspects of such a philosophy based on the preservation of religion.

To be sure, a mature *maqāṣid*-based philosophy would necessarily inform the ethical goals and practices of healthcare and, in turn, generate frameworks for health policy and medical ethics. To the best of my knowledge, no scholar has undertaken this task; piecemeal efforts to create functional frameworks for different aspects of clinical care exist but no formal, systematic approach to delineate philosophical bases for practice has been proffered.

This chapter begins to fill in this gap. It aims to spur holistic, top–down approaches that use the *maqāṣid* first to define health and determine healthcare priorities and then to implement these priorities in practices, policies, and ethics. Finally, delineating the relative weight that should be accorded to life and religion offers insight into how *maqāṣid* thought could attend to concerns over the role of

religion in contemporary healthcare, which I will address in the closing section of this chapter.

Why the Preservation of Human Interests?

Before diving into debates about the highest good according to *maqāṣid* theories it is necessary to review some of the foundational premises and theological understandings upon which *maqāṣid* theories are predicated. The most fundamental concept undergirding Islamic legal theory is that God legislates purposefully. In light of the Lawgiver's purposiveness, it is possible for humankind (via the use of reason) to discern specific purposes behind scriptural laws with a relative degree of certainty.[1] Said another way, it is held that these purposes, in so far as they relate to the human welfare, are communicated through revelation and knowable.[2] It is on this basis that overarching objectives of Islamic law can be identified, and resultantly Islamic law can be extended to cover novel issues via analogical reasoning.

As Nyazee notes in his introduction to al-Shāṭibī's *al-Muwafaqqāt fi Uṣūl al-Sharīᶜah*, the majority of classical and contemporary Islamic scholars agree that the most general and fundamental reason behind God's commands is "securing the interests of the servants [human beings] in both the here and the hereafter."[3] Within his tome, al-Shāṭibī goes on to explain why securing human interests is the ultimate purpose of legislation, why Divine purposes must be, to a relative degree of certainty, knowable, and detail how God imposes obligations upon human beings based on their capacity to perform actions, and why a primary objective of *Sharīᶜah* law is to "free the subject from the exigencies of his own whims so that he may be the servant of Allah by choice."[4] He demonstrates that the concern for human welfare in this life and the next is at the heart of Islamic law.

As Islamic legists build out Islamic ethico-legal theories and develop fiqh based on the notion of identifiable and beneficial

purposes to laws within revelation, they are motivated by a pragmatic duty to provide Muslims with guidance about how to arrange their lives so as to secure Divine pleasure and salvation. Theological perspectives on using reason to generate Islamic laws afresh and whether human benefit is always the reason for Divine legislation, however, remain divided and involve multiple ancillary issues. For example, if God legislates to secure benefit for humankind, is this because He is somehow compelled to do so? Similarly, if God's purposes are scrutable to human reason, are humans obligated to follow God's commands when reason finds that human interests are threatened? In this way, Islamic versions of the 'Euthyphro dilemma' emerge.[5]

Generally speaking, responses to these and related questions divide theologians into three camps. The first group, the Muʿtazilites, hold that 'God commands the good because it is good', that is, that the qualities of 'goodness' (benefit) or 'badness' (harm) inhere within actions and are discernable by human reason. They also consider that justice to underlie all Divine actions and commands. Consequently, human reason has wide latitude to promulgate Islamic laws based on notions of human benefit and harm.

The second camp takes the radically opposite position by holding that 'actions are good because God commanded them', that is, there is no inherent quality to human action, and that revelation is the only trustworthy guide to Islamic normativity. As such, human reason is not a reliable source of morality and cannot be used, independently, to generate Islamic laws based on human benefit. This camp is the Ashʿari school of theology, and they argue that the Muʿtazilite perspective threatens God's omnipotence since it subjects God to acting in accordance with human notions of benefit and harm.

The third camp, the Matūridī, advocates a middle position by holding that Divine actions and commandments emerge from His grace. Because of this Divine laws secure human benefits in this world and the hereafter. Worldly benefits are usually, but not always, accessible to human reason, however the afterlife benefits are enumerated

within revelation. They also hold that God is not compelled to act in the interests of humankind. Accordingly, human reason is dependent on revelation but has a definitive role in identifying Divine purposes and generating Islamic law.[6]

These theological positions were read into the theories of Islamic legal schools, since both the methods used to ascribe causes behind Divine action and to delineate the rationale behind His commandments must be consistent with a given school's accepted theological doctrine. Ultimately, sophisticated reasoning allowed for ascribing epistemic authority to human reason so that it could, to a relative degree of certainty and with limited scope, discern Divine purposes and generate Islamic law.[7] This détente set the stage for developing the science of identifying *maqāṣid* within revelation and the resulting legal theories and frameworks. To be sure, the Sunni schools of law envisage law as serving human ends because God intends for it to do so, and they deem the use of rational methods to weigh the benefits and harms of human action as an acceptable modality for discerning where Divine will resides.

Which Has a Higher Priority: The Preservation of Life or Religion?

The preceding review brings us back to the *maqāṣid* which designate specific human interests as deserving of preservation. As described in Chapter 2, al-Shāṭibī considers five human interests to be of greatest import: religion (*dīn*), life (*nafs*), progeny (*naṣl*), material wealth (*māl*), and intellect (*ʿaql*). While other classical and contemporary theorists tweak al-Shāṭibī's conceptions of these interests, or add additional ones, within their models, these five interests remain sacrosanct across *maqāṣid* thought. Each of these interests deserves preservation, with preservation entailing two complementary aspects: a 'positive' duty to establish and maintain the existence of that interest and a 'negative' duty to protect that interest from being extinguished.[8] Most jurists acknowledge that Islamic laws must privilege these five

interests over all others, and their preservation is moral imperative at both the individual and larger societal levels.

Nonetheless, legists disagree on the hierarchal order among the five interests and vigorously debate whether the prime interest is religion or life. Imam al-Ghazālī (d. 1111), the polymath theologian-jurist and al-Shāṭibī's predecessor, ordered the interests with religion first, followed by life, intellect, progeny, and material wealth. Sayf al-Dīn al-Āmidī (d. 1233), another prominent theologian-jurist and predecessor of al-Shāṭibī's, also prioritizes religion over life, though he reorders the remaining three as progeny, intellect, and material wealth. On the other hand, other eminent jurists of the classical period, such as Qadi al-Bayḍāwī (d. 1319) and Ibn Taymiyyah (d. 1328), place human life above the interest of religion, with al-Bayḍāwī ordering the remaining three as intellect, material wealth, and progeny and Ibn Taymiyyah's order being life, material wealth, honor (instead of progeny), intellect, and religion.[9]

The case for placing the interest of religion over human life is based on several arguments. For one, al-Shāṭibī and others draw support from commandments within revelation. Recall that al-Shāṭibī used induction to discern the essential higher objectives of Islamic law, and that his search began with analyzing commandments within the Qur'an that instructed humankind to perform certain actions and leave off others. One core set of commandments he examined were those that allowed for the taking of life; in his view, a higher order interest was at stake whenever God and the Prophet Muhammad sanctioned the taking of life. Therefore, al-Shāṭibī claims that the command to fight the unbelievers and, in so doing, possibly forfeit one's life, as well as the institution of capital punishment for apostasy, reveal that the preservation of religion[10] is of greater importance than the preservation of human life. He also argues that the core nature of religious law is that it makes all interests in this world subservient to the interests of the hereafter. Thus, Islamic laws must make the ultimate interest of the hereafter (i.e., salvation) primary. Consequently,

giving up one's life in the course of jihad to secure one's own salvation and/or that of others, or sacrificing many lives on the battlefield to secure salvation for greater numbers of people, affirms that priority should be given to the preservation of religion over the preservation of life. Al-Shāṭibī further expounds on this by underscoring that the interest of religion he refers to in his model is the idea of communal religion, not simply an individualized practice of the faith. Indeed, the rulings he quotes allow for the taking of life so that Islam at the societal level is secured. Individuals, on the other hand, are allowed to utter words of apostasy if compelled to do so to protect their own lives.

Other prominent scholars confirm the priority of religion over all other interests based on similar reasoning. For example, Adi Setia quotes the contemporary Islamic theologian Syed Naquib al-Attas to explain that "an ostensible benefit in this life that leads to a harm in the afterlife is, in reality, not a benefit at all,"[11] hence all benefits and harms of this world must be subjected to scrutiny from an afterlife perspective. This process intrinsically places preservation of religion as the ultimate objective with all other objectives existing as supports. In the words of the pre-eminent Islamic jurist Muḥammad Saʿīd Ramaḍān al-Būṭī (d. 2013), "the interest of the religion is the foundation of all other interests."[12]

Other legists support this argument by drawing upon scriptural sources such as the Qur'anic verse that declares, "I did not create jinn and humankind except to worship Me" (51:56), and a statement from the Prophet Muhammad that "God's religion is most worthy of implementation."[13] To these evidences I would add other scriptural statements that indicate that the life of this world is of instrumental value to the hereafter, both at the individual level and the collective one. For example, when the Prophet's Companions inquired as to whether they could wish and pray for death, he responded that "none of you should wish for death. If he is righteous, perhaps he may add to (his) good works, and if he is a sinner, possibly he may repent (in case

he is given a longer life)."[14] This and similar statements indicate that the potential of performing deeds which may elevate one's station in the hereafter is what gives value to life. Further highlighting the instrumental value of life to merit-making for the hereafter, he taught his Companions the following prayer: "O Allah! Give my life so long as the life is good for me, and take away my life if death is good for me."[15]

On the other hand, scholars who consider human life to have greater significance than religion find support in other scriptural statements, and, additionally, in established legal precedent. For example, they note that most jurists who prioritize religion over life, including al-Ghazālī, rule that if a person is under duress, it is permissible to utter words of apostasy. They suggest that since the Qur'an explicitly allows an individual to partake of alcohol, carrion, or porcine-based foods when dying of thirst or starvation,[16] preserving life is of greater importance than following God's commands that prohibit the consumption of these materials. Similarly, they note that scripturally affirmed exemptions from fasting when one is ill and allowances to shorten prayer while on a journey indicate that a potential threat to human life (e.g., illnesses, hardships in living, and/or the onerous demands of travel) are sufficient to relax religious duties. Implicitly, then, human life warrants higher priority than the performative aspects of religion. Some legists go as far as saying that a Muslim is obligated to abandon individual religious obligations such as fasting and prayer as well as collective duties such as waging jihad if "one is threatened with death for engaging in them."[17] A precedent that allows for abandoning one's prayer to save another person's life further supports this argument. Another line of reasoning used to privilege life over religion comes from the idea of human rights and God's rights in Islam.[18] The argument goes that religion falls within the domain of God's rights, since religious duties are owed to Him and because religion orients individuals toward God. However, God does not need human worship and acknowledgment for He is

beyond all needs; nor does the existence or non-existence of the global religion of Islam affect Him in any way. On the other hand, the lack of fulfillment of obligations owed to human beings leaves them deprived. Hence, if the forfeiting of one's life to fulfill the obligations of religion leads to deprivation of other human beings' rights, then one's life should not be forfeited. Attia quotes al-Āmidī, who refers to his interlocutors' arguments that exemplify this line of reasoning when they say, "God Almighty suffers no harm if His right is forfeited; hence the preservation of [the creature's right] is of greater importance" and "we give higher priority to human life than to the interests of religion since we alleviate hardship for those who are on a journey by allowing them to shorten their prayers… [and] we exempt travelers from having to fast, and we allow someone who is ill to pray while sitting… and to forgo fasting."[19] Attia seems inclined to this view, as he argues that the interests of religion cannot exist without human life and places other interests over religion and personal piety in his *maqāṣid* theory.

Despite their differences, the opposing perspectives can be reconciled. One strategy that accomplishes this alignment is by differentiating the preservation of religion at the collective or societal level from preserving religious practices and identity at the individual level. As noted above, al-Shāṭibī's theory seems to accommodate such a resolution. Recall that al-Shāṭibī's *maqāṣid* are enumerated at the level of society and the hierarchy he specifies applies to moral objectives at that level of action. His theory does not necessarily advance moral obligations at the level of an individual, hence some scholars advance the argument that at the individual level human life should be given priority. Such a prioritization is consistent with the legal permission to utter words of apostasy to preserve one's life. In contrast, at the collective level, the existence of Islam must be secured by forfeiting life. A similar line of reasoning is taken by the Al-Azhar-trained theologian Muhammad Darraz (d. 1958), whose commentary on al-Shāṭibī's theory is quoted by Attia "when the preservation of

religion is given precedence over the preservation of human life, this is only to preserve the root [i.e., the fundamentals] of religion. However, in relation to its branches, we find that the Lawgiver often exempts human beings from religious obligations for the sake of preserving human life as in the case of illness."[20]

I find myself inclined to the view that the preservation of human life is subsidiary to the preservation of religion at the societal/communal/universal level for the reasons enumerated above and another reason as well. This additional reason is as follows: Islamic law *permits* but does not *obligate* an individual to utter the words of apostasy to save his or her life, and similarly, there is no consensus whether the human being is *obligated* to eat normatively impermissible items to save one's life (the prevailing Ḥanafī position, for example, is that one cannot cannibalize to save one's life). In my view, it can be argued that even at the individual level, one does not necessarily need to privilege human life over religion. However, in the case that one does, there is no sin. Therefore, in terms of societal-level morality, the most appropriate hierarchical order is that the human interest of religion is placed above the interest of life. At the individual level, contextual considerations and individual preferences can allow for either interest to occupy the highest position.

Preserving Religion in Healthcare

Now that we have resolved that the highest order objective of Islamic law is the preservation of religion, one could ask whether this hierarchy also applies to societal healthcare delivery. The answer to this question is not immediately apparent. Some *maqāṣid* theorists argue that hierarchies among interests must be recalibrated at each social register. Hence priorities at the level of an individual can differ from those at the level of communal life, and the hierarchy at the level of general society can be different from those at lower levels. Others argue that the actualization of human welfare requires a consistent

Islamic axiology across all levels of society. Most *maqāṣid* theorists prefer this latter view as they delineate higher objectives that are universally applicable across society.

Moving on, if one were to accept that preserving religion has priority over preserving life, then several conceptual, ethical, and practical questions arise: What sort of philosophy of healthcare emerges from the highest objective of preserving religion? What does a healthcare system that considers the preservation of religion to be of primary import look like? What are the services it offers, and how do healthcare practitioners within it function? What sorts of ethical guidelines and healthcare policies are needed to resolve conflicts that arise when the interests of religion oppose the interest in life? For example, would individuals be allowed to forgo life-sustaining treatment due to religious objections? And would healthcare providers be allowed to refuse providing life-saving therapies because they clash with their own religious commitments? These sorts of questions are of particular interest, given controversies surrounding the role of religion in contemporary healthcare today.[21]

Tensions Over the Place of Religion in Contemporary Healthcare

As noted in Chapter 1, biomedicine is reductionist as it embeds European Enlightenment Era naturalism and a positivist view of bioscience that privileges empiricism and the physical aspect of human health. This intellectual heritage also influences secularist impulses within healthcare delivery. Generally speaking, there is a dividing line between religion and science with healthcare delivery being rooted in science. Thus, in so far as healthcare delivery is concerned, religious beliefs and values are viewed with skepticism, and policy accommodations for religious practices require significant justification. Within broader society however religious and liberal secular spheres can coexist, each with their own distinct and generally incommensurable discourses. Yet, religious arguments, if welcome at

all, that are proffered within the secular and liberal public square must be recoded in terms that are relevant to that discourse, i.e. in rational terms without appeal to any metaphysical elements.

As a byproduct of this socio-historical background and the previously discussed global dominance of biomedically oriented healthcare systems, nearly all frameworks used to assess health behaviors and health determinants, as well as for healthcare system design, tend to omit religion as a factor. Indeed, religion's role in shaping health beliefs, influencing health behaviors, providing healing, and informing patient needs is routinely overlooked. As such, the religious needs of patients are addressed at the periphery of allopathic medicine.

This marginalization is not merely passive. Studies of hospital chaplains, who are uniquely positioned to serve the religion-related needs of patients, reveal a general systemic aversion to religious thought and pervasive anti-religious sentiment among staff, administrators, and other healthcare professionals. Consequently, in order to gain purchase within this environment, chaplains often adopt vocabularies that convert religion into culture and religious rituals into spiritual practices.[22] In this way they can better advocate for their patients' religious needs. This project of translation also effectually remolds healthcare chaplaincy into a non-denominational interfaith practice no longer anchored to religious traditions. Instead of being trained to perform religious doctrines, rituals, and healing methods and serving specific religious communities, healthcare chaplaincy training focuses on providing spiritual support through active listening and non-directive counseling. This emptying of religious content is founded on the premise that the healthcare system must be able to tend both to individuals of particular faiths and to those of no faith at all; hence the practices of healthcare chaplaincy must become focused less on religious doctrines and more on faith experiences, less on theology and more on spirituality; less on normative counseling and more on personal meaning-making.[23] And, finally, current societal trends in Western societies showing a decline in religious affiliation

add further impetus to refashion healthcare chaplains into a more generic service providers.[24]

Beyond hospital chaplaincy, the relevance of religion to clinician practices and within bioethical discourse is also scrutinized under the general premise that, as anthropologist Lisa Stevenson concisely notes, "religion must exist in the hospital in such a way that it neither threatens the epistemology nor reach of biomedicine."[25] For example, the role of physicians in tending to the religious and spiritual needs of patients is debated. Some scholars argue that physicians are ill-trained to assess the spiritual needs of patients and are not skilled in properly addressing these needs. Hence clinicians should leave such assessment and counseling to healthcare chaplains and religious clergy.[26] Besides the lack of training, commentators note that clinicians' venturing into this area poses conflicts of interest and opens up the possibility of patient coercion. Clinicians are trained to provide biomedical therapeutics and necessarily believe that these therapies offer the best chance at restoring a patient's health. As such, they may deem religious modalities of healing as less efficacious and possibly dissuade patients from their pursuit, or, alternatively, use religious language to convince patients that the biomedical option is the best one. For these reasons, some advocate for a clear boundary between clinicians as purveyors of biomedicine and other professionals who attend to questions of religious ethics and provide spiritual support.[27]

In addition to the dangers of physicians venturing into the patient's religious identity and practices, research finds that physician religiosity can lead to variance in clinical care. Said another way, physicians' commitments to their own religious traditions influences the types of clinical care patients receive.[28] In some clinical domains (e.g., reproductive health), therapeutic options may be unavailable to some patients because their physician holds a religious objection to that modality, a restriction of patient choice and potential harm thus ensues.[29] On the basis of empirical evidence of such occurrences and in defense of a liberalist ideology, some scholars argue that physicians

claims of conscience should be restricted.[30] In effect, the argument is that physician religiosity should be subservient to patient care. Needless to say the debate continues.[31]

The role of religion in bioethics discourses is also controversial. Building off the idea of a secular public square where public reason[32] dominates ethical deliberation, some scholars argue that religiously sourced ethical arguments are not part of academic bioethics discourse.[33] Similarly, others argue that religious arguments must be approached with skepticism and have no place in normative medical ethics deliberation.[34] In response to these secularist positions, other scholars appeal to the fact that religion strongly informs the attitudes and behaviors of patients, providers, and policymakers and that religion-based arguments involve rational reasoning. Hence religion cannot be excised from bioethical discourse and deliberation.[35] Here too the debates rage on.

Beyond these examples, the admixture of religion and biomedicine also stirs controversy when it comes to therapeutics and community partnership. Religion-related healing modalities become subject to verification by empirical methods borne from positivist science, which implicitly rule out the existence and possible health effects of forces that are beyond the grasp of bioscience. As healthcare systems move to tackle community health issues, they partner with religious communities to screen and treat patients. In these partnerships scholars confront the question of whether biomedicine has simply expanded its reach by bringing biomedicine into religious sites (i.e., faith-placed interventions) or whether partnerships are authentically faith-based in that the goals of religion are of primary import and health programs are framed as part of living a religious life.[36]

In summary, the place of religion in contemporary healthcare is subject to great debate and controversy. Nonetheless, the positive benefit religious practices and communities offer to health are undeniable.[37] A societal healthcare system cannot afford to ignore the religiosity of its patients nor its providers, and it cannot be effective

without partnering with religious communities. Indeed, both religion and biomedicine answer fundamental questions about the human being such as its origin and end, provide powerful models to explain human experiences of illness and wellness, and offer solutions to human maladies. Yet, religion and biomedicine operate within different epistemic and ontological frameworks, and those differing approaches generate controversies in healthcare delivery. *Maqāṣid*-based engagement with biomedicine must account for these controversies.

Prioritizing Religion in Healthcare

In Chapter 6, I highlighted how it is necessary for *maqāṣid*-based models of medical ethics to declare which ethical goal—the preservation of religion or the preservation of human life—is paramount. Without such clarification, it is impossible to resolve conflicts between these moral imperatives at the bedside. Our preceding discussion suggests that these models should give primacy to preservation of religion. Relevant to this domain is a contribution from Shaykh Ali al-Qaradaghi, a Doha-based Islamic jurist and member of the International Union of Muslim Scholars. He sets the preservation of religion over the preservation of life, and discusses how each ethical objective can be applied in medical ethics deliberation. In so doing, he describes two aspects to preserving religion. The first involves holding fast to virtues such as honesty, kindness, and generosity in caring for patients because these character traits are affirmed by Islam. The second aspect entails avoiding practices that undermine a patient's religious commitments. Hence therapeutics that are contrary to a patient's religious beliefs and values should be avoided by the treating team. This responsibility is shared by both the clinical team and the patient in that clinicians should seek out alternative treatments that accord with the patient's religious commitments, and patients must adhere to the religious rulings that proscribe some

treatment modalities.[38] More generally, al-Qaradaghi states that Muslim physicians must abstain from all acts that are deemed religiously forbidden by the *Sharīᶜah* in order to live out the preservation of religion in healthcare.[39] It thus appears that the moral imperative of preserving religion would support claims of conscience on the part of patients, and honor patients' refusal of treatment on account of religious convictions.

Moving upward from the bedside, there are other ways in which the preservation of religion can animate healthcare system practices. At the level of patient and provider experiences, healthcare systems can acknowledge provider and patient religious identities by supporting their religious practices, observances, and values and providing accommodations where necessary.

Using Muslims as an example, preserving religious *practices* such as the ability to perform ritual prayers, participate in *Jumuᶜah* services, or to fast would require supportive environments and policies. Studies of Muslim providers within the United States reveal that they often struggle to pray at work,[40] and some Muslim patients feel uncomfortable praying in hospitals for fear of discrimination and due to the lack of places to pray that are free of religious iconography.[41] Similarly, Muslim clinicians find it difficult to fully participate in Ramadan fasting and rituals because their workloads are not adjusted to accommodate their fasting. Adhering to the imperative to preserve religion may require hospital systems to develop policies that allow clinicians to take strategic breaks in order to perform their prayers, to designate neutral spaces in the hospital for patients and providers to pray, and to consider work schedules that align better with Ramadan practices.

Religious *observances* cover the observance of holidays and wearing religious garb such as the *ḥijāb* or beard. Protecting the healthcare staff and patient's rights to fulfill these observances aligns with the moral imperative of preserving religion. Yet, female Muslim staff and patients at hospitals in the West face discrimination when wearing *ḥijāb*, and operating theater policies have yet to develop

consistent work-arounds to allow for donning and doffing with sterility while wearing the *ḥijāb*. Similarly, for men the beard can pose a challenge. For example, during the worst phases of COVID-19 there were insufficient quantities of powered air-purifying respirators to allow staff with beards to work safely. As such, many Muslims were forced to shave their beards to protect themselves and their patients from disease risk.[42] Furthermore, in many healthcare systems in the non-Muslim world Muslim religious holidays are not officially recognized, often leading staff to either use precious vacation time or forgo celebrating. Accommodating religious observances requires multi-level policy action including staffing rules allowing for days off during religious holidays, workplace guidelines that accommodate wearing religious garb, and procurement of sufficient resources so that religious individuals do not have to choose between religious observances and work.

The preservation of religion may also entail accommodating religious *values*. As discussed previously, patients and providers may find some therapeutics to conflict with their religious ethics. While claims of conscience may provide clinicians with recourse to avoid participation, patients require a different solution. It is quite possible that the only treatment for a certain condition involves a normatively prohibited procedure. In this case, the patient may have to partake on account of dire necessity. In my view, this state of affairs is non-ideal as it places the onus on patients to accommodate conventional biomedical procedures and practices. Instead, healthcare systems should design solutions that do not force patients to seek exemptions from religious law. A great example of this push toward solutions is represented by the advent of bloodless surgical techniques on account of, at least partially, the religious prohibition of Jehovah's Witness patients from receiving blood transfusions.[43] Another example from the Muslim world revolves around the creation of vaccine formulations that do not involve porcine components.[44]

Accommodating religious values may also require modifications in medical education. It is commonplace for cadavers to be used to educate medical trainees on human anatomy, for non-patients to serve as human models so that medical students can learn genital examination techniques,[45] and abortion clinics used to instruct trainees about gynecological procedures and pelvic ultrasonography. Each of these educational modalities may be met with objections from religiously adherent trainees. Cadaver use is frowned upon in Islamic ethics due to its disruption of the inviolability of the human body;[46] the use of actors' bodies constitutes an affront to notions of modesty in many cultures; and abortion elicits objections in many Christian circles. Finding alternative teaching tools that do not compromise the faith commitments of medical trainees coheres with the mandate of preserving religion.

At the deeper conceptual level, the preservation of religion may require acknowledging an ontology of healing that is broader and more inclusive than the biomedical model. Illustratively, an Islamic ontology of healing recognizes that God is the ultimate Healer and consequently sees practices such as prayer, charitable giving, and fasting as avenues by which to seek cure.[47] Similarly, Prophetic traditions direct Muslims to partake of specific herbs for certain ailments, and that *zam zam* water and *ruqyah*[48] have healing power.[49] Similarly, the Qur'an notes honey to have curative potential (See Qur'an 16:68–69). Inquiring about religious treatment modalities used by patients, encouraging them to seek trained traditional healers who can guide their usage of these modalities, and making discussions about religious therapies a standard part of patient history taking, can also be motivated by a commitment to the preservation of religion.

Finally, the preservation of religion could inform distinctive philosophies of care. A prominent example of this is the development of *ᶜibadāt*-friendly (worship-friendly) hospitals in Malaysia.[50] According to their founders, such hospitals emerge from the dual recognition that the core purpose of a human being's existence is to worship God

(cf. Qur'an 51:56) and many patients struggle to worship when hospitalized. Thus, the entire healthcare experience is organized around facilitating worship. Patients are instructed on the rules of prayer and fasting while ill, each patient is provided with a kit that contains material to facilitate worship such as a *qiblah* finder, a parcel of dust for dry ablution, and head coverings for prayer. Furthermore, nursing staff aid patients with ablution and remind them of prayer times upon request. At the same time, worship-friendly hospitals ensure that all policies and procedures are in line with the dictates of the *Sharīʿah*. These practices allow the ethos of preserving religion to flourish in healthcare.

In closing, there are multiple ways in which the moral imperative of preserving religion could shape the ethics, practice, and philosophy of healthcare delivery. While I have shared examples that focus on Muslim identity, similar attention could, and should, be paid to the practices, observances and values of other religious communities. There is a critical need for religious scholars, healthcare practitioners, patients, and policymakers to collaborate toward designing healthcare systems that carry out the mission of preserving religion alongside the pursuit of restoring and promoting health. As a parting response to the question that framed this chapter I would offer that healthcare systems organized around the preservation of religion could readily subsume life-affirming healthcare practices under this goal, however systems organized around the preservation of life are more likely to overlook, and thus underserve, the religious values, practices, and observances of patients and clinicians.

8

CONCLUSION: THE PERILS AND PROMISE OF INTEGRATING MAQĀṢID IN BIOMEDICINE

Renowned scholar and founding Chairman of the International Institute of Advanced Islamic Studies in Malaysia Mohammad Hashim Kamali describes five phases of research into the *maqāṣid*. The first phase involves archival research to consolidate and scrutinize classical scholars' views on the subject. The second entails the construction of theoretical frameworks that account for the epistemological and procedural questions related to identifying and implementing the *maqāṣid*. Calibrating *maqāṣid*-based ethical and legal analyses and analyzing how they mesh with existing fiqh rulings comprises the third phase of research. The fourth phase involves applying *maqāṣid* frameworks to specific fields, domains of inquiry, and contemporary issues. The fifth phase, a problematic one, advances utilitarian goals in the name of Islam through unprincipled implementation and nefarious cooption of *maqāṣid* frameworks. Kamali considers the first phase completed, while phases two and four are ongoing because methodological issues around the identification and application of *maqāṣid* have yet to be fully resolved. Phase three also continues as legists consider how to integrate *maqāṣid*-based analyses in the process of ijtihad. While he decries the lip service given to the *maqāṣid* by professionals and policymakers when justifying their programs, à la phase five, he is heartened by the possibility that the moral values embedded within the *maqāṣid* can authentically inform social policy and ethics. And he is optimistic that novel, multidisciplinary approaches will solve problems with identifying the *maqāṣid*, applying them to distinct fields, and implementing them in society.[1]

As seen in the preceding chapters, these five phases of development are apparent in the current dialogue between biomedicine and the *maqāṣid*. Chapters 1 and 3 align with phase one of Kamali's schema as theories of the *maqāṣid* were reviewed, and notions of human health embedded in these theories were distilled. Chapter 4 detailed an approach to health policy derived from the *maqāṣid*, while Chapter 5 assessed the application of the *maqāṣid* to medical ethics. These two chapters accord with phase four research. Chapter 6, on the other hand, critiqued the deliberative model for medical ethics and compared the proposed ethical solutions to extant fiqh. Thus, it encompassed research phases three, four, and five. Finally, Chapters 2 and 7 cover epistemic concerns, analytical quandaries, and societal implementation issues that relate to phases two and four. Accordingly, this book initiates the reader to the gamut of *maqāṣid* research while delving into pressing questions at the intersection of Islam and biomedicine. In this closing chapter, I comment on critical issues that inhibit the integration of *maqāṣid* within biomedicine and outline provisional strategies for tackling these problems.

Problems at the Interface between the *Maqāṣid* and Biomedicine

Complex conceptual, methodological, and cultural issues hinder the integration of moral frameworks from the *maqāṣid* within contemporary biomedical practice and health policy.

Conceptual Issues: What are the Human Interests and Moral Obligations Attached to the *Maqāṣid*?

In previous chapters, I discussed differences among Islamic scholars on the set of human interests enveloped by the *maqāṣid al-Sharīʿah*. Based on their readings of scripture, classical Islamic legists advanced many different but scripturally rooted interests as ones deemed important by the Lawgiver. More contemporary scholars, however,

have introduced greater variability by adding interests that are, at best, tangentially referred to by scripture. The resulting ambiguity about what the interests are and whether it is proper to redefine them based on societal needs hamstrings efforts to integrate the moral dimensions of *maqāṣid* into biomedicine.

Illustratively, although the five essential higher objectives of preserving religion (*dīn*), human life (*nafs*), progeny (*naṣl*), material wealth (*māl*), and intellect (*ᶜaql*) are widely quoted in the Muslim biomedical circles, there is a lack of clarity about what values they preserve.[2] Is the interest of human life limited to the life of this world or does it extend to one's position in the hereafter? Does the interest of religion refer to preserving Islam or to protecting the freedom to choose any or no religion?[3] The same sort of conceptual uncertainty plagues interests that have been added beyond the traditional five. For example, if one adds human health as a core interest, then what vision of human health are the *maqāṣid* to preserve?[4] Without a clear definition of the interests, one cannot advance their preservation through biomedical ethics, practice, and policy.

The genius of classical *maqāṣid* theorists was to uncover core interests by examining scripture. Hence these interests were, at least theoretically, bounded by the Qur'an and Sunnah. To be sure, there remained modest debate regarding the contours of these interests, for example, whether scriptural indicants referred to the interest of progeny or lineage. However, these debates have widened significantly. Nowadays, scholars and thinkers 'find' many different human interests within revelation and place them within the essential *maqāṣid*. One wonders the extent to which some of these new interests (e.g., intellectual property) are truly exegetical or instead products of eisegesis, in other words, are read *into* rather than *out of* scripture. Pushing boundaries even further, some thinkers decouple the core interests from scripture by introducing values based on reasoning about the natural world or contemporary society.

In the classical period, given that scripture-based analysis was required to identify the essential interests, scholars had to justify their views based on scriptural knowledge and hermeneutics. Differences in definitions had to be resolved by recourse to scripture. Yet, as the foundation for interests shifts from scripture to other domains of knowledge, the need for a *maqāṣid* theorist to be steeped in scriptural knowledge is somewhat lessened. Conversely, the need for being versed in various contemporary sciences is somewhat increased. The broadening of the expertise needed to identify and define human interests promises to solve some problems (as discussed below) but also exacerbates others.

For one, uncertainty about what the interests are has grown. This increased uncertainty results from removing the scriptural anchor that originally bounded definitions of the interest. Take, for example, the idea that justice is a core interest that must be preserved by Islamic law. One could define justice through scriptural texts. If that is the sole grounds for conceptualization, then debates about what justice means would be limited to interpretations of a limited number of scriptural sources. While multiple divergent readings are likely under this methodology, those different conceptions would still remain individually quantifiable, and thus a consensus-based definition would be possible. However, if one is not constrained by scripture, one could mine any number of philosophical, sociological, and legal theories to fill out a definition of justice. Under this approach, the assortment of possible readings is thus significantly increased. As a result, consensus about what justice means and demands falls further out of reach. It is critical for theorists to define comprehensively, and come to a consensus about, the human interests Islamic morality must preserve. Critical analyses and implementation research proceed only after the interests are concretely specified. If the interests remain ambiguous, stakeholders remain unsure about what Islamic morality demands. And, if they remain open to redefinition at will, then the number of possible models for the *maqāṣid al-Sharīᶜah* would

effectively become limitless, thus undermining the theory's conceptual consistency and claims to universality.

In addition, allowing for human reason to independently arrive at the *maqāṣid* links back to classical debates over the authority of human reason. Although I have referenced some of these debates in Chapter 7, it is beyond the scope of this book to fully detail these contestations. Still, it suffices to say that the debates revolved around whether human reason could reliably discern the good, whether revelation was the only guide to the good, and whether goodness was a quality inherent in human action or simply a label attached to human actions by God. Another aspect of the debate related to God's actions and will: specifically, the question is whether His actions were in accordance with the good due to compulsion or out of His Grace.[5] These theological debates influenced the development of Islamic legal theory and still persist in contestations over the use of *maṣlaḥah* as an independent source of law in Sunni Islam.

Since *maqāṣid* theories build upon notions of *maṣlaḥah*, they cannot wholly bypass debates around whether extra-textual interests are sufficient to set moral obligations. This presents another concern: using the *maqāṣid* may expand the sorts of activities and behaviors Muslims are obligated to perform. To illustrate this, imagine that an expanded notion of justice is integrated into the *maqāṣid*, and subsequently, Muslim leaders use this notion to motivate Muslim attitudes toward specific policies.[6] Is support for that policy a moral imperative? In other words, are Muslims, both at the individual and collective level, contravening God's will should they not live out this specific call to justice? In Islamic legal theory, a moral imperative/obligation refers either to: (i) a command to perform an act, and if that act is not performed, sin accrues for nonperforming individuals or communities, or to (ii) a command to not perform an act, and if that act is performed sin accrues. The inherent plurality of Islamic law restricts this zone of moral obligation rather closely; if there is scholarly disagreement about whether an action is morally obligated

then that action cannot be conclusively judged to be morally obligated and as such sin cannot be ascribed to non-performance. When stakeholders appeal to the *maqāṣid al-Sharīᶜah*, they purposefully flatten this diversity of opinion by calling attention to a supposedly consensus-based underlying 'spirit' of Islamic morality. Yet, setting a moral obligation based on a hybrid notion of justice derived from both revelatory and non-revelatory sources allows non-scriptural notions to levy sin. While advocates of *maqāṣid*-based approaches to ethics, law, and policy-making may want to incorporate contemporary ideas into their definitions of the human interests, expanding Islamic moral obligations based on these ideas is the unintended effect. This 'creep' is antithetical to the science of *uṣūl al-fiqh*, which demands a high level of scriptural evidence to establish moral obligations and attribute sin to their performance or non-performance.

Additionally, many thinkers use the *maqāṣid* to motivate Muslim behavior by injecting Islamic morality into science and society. However, these thinkers are circumspect about what level of moral obligation emerges from their *maqāṣid*-based analyses. For example, advocates of using *maqāṣid* frameworks for medical ethics deliberation do not spell out whether sin accrues if the proffered guidance is not acted upon. And even if we suppose the conventional notion of obligation is meant where non-performance accrues sin, the situation is highly problematic. In this case, rather than lessening the trend of hyper-legalism of Islamic ethics and Muslim society the adoption of *maqāṣid* may indeed further bolster it.

In summary, it remains unclear what interests the *maqāṣid* advance and what moral obligations they demand. These conceptual issues must be resolved in order for *maqāṣid* frameworks to be applied in biomedicine.

Methodological Issues: How to Implement the *Maqāṣid*?

Once the *maqāṣid* are better defined and understood, the issue of how

to use them arises. This includes difficulties related to organizing society, making policies, and analyzing ethical issues based on them. Most of this book addresses these challenges. In Chapter 3, I proposed a conception of human health based on the *maqāṣid al-Sharīʿah* to set up end goals for healthcare. In Chapter 4, I laid out how the imperative to preserve human life can furnish health policy agendas. In Chapter 7, I suggested how the preservation of religion can shape the philosophy and practices of healthcare delivery. These strategies lay a foundation for further research to build out feasible and robust methods for integrating *maqāṣid*-based morality into biomedicine and healthcare.

In addition to having deep knowledge of Islamic moral frameworks, implementation of the *maqāṣid* requires great understanding of the forces that shape biomedicine and healthcare delivery, as well as granular insight into the needs of the end-users. My analyses illustrate the dire need for multilevel analyses that reveal how biomedical discourses and healthcare systems operate before applying *maqāṣid* within this space. They also speak to the need for multidisciplinary efforts to fine-tune and fill out the theoretical and practical frameworks of the *maqāṣid*.

For example, in the health policy realm, it is critically important to recognize that various theories of the *maqāṣid al-Sharīʿah* are incomplete. As a case in point, al-Shāṭibī's theory leaves the necessary and enhancing objectives unspecified. He states that these secondary objectives are set after thorough analyses of the implementation context's social, legal, ethical, and cultural dimensions. Indeed, generating moral imperatives without extensive knowledge of the context can result in misapplied morality. Individuals using al-Shāṭibī's model in biomedicine have not, to my knowledge, undertaken such multi-level analyses. Thus the model they deploy lacks critical supports. Other models contain similar methodological gaps. Attia's model, for example, requires that the means by which the higher objectives are achieved are categorized as essential, necessary,

or enhancing, must be based on a harm-benefit analysis. Yet, his theory does not provide an epistemological framework for, nor a practice through which, such analyses are to be performed. Again, the theory is missing elements necessary for implementation.

Another critical challenge that implementers face is the unsettled hierarchy among the *maqāṣid*. Medical ethics deliberation cannot occur without knowing which value to prioritize and how to balance competing interests. Policy and legislative frameworks also require these details. Similarly, agreed-upon mechanisms for adjudicating conflicts between fiqh rulings and *maqāṣid* analyses remain wanting. In summary, critical methods for applying *maqāṣid* theories and frameworks remain to be delineated, and as such, they are not yet ready for implementation in policy, fiqh, and ethics circles.

Cultural Issues: Is Contemporary Biomedicine Ready to Consider the *Maqāṣid*?

For lack of a better term, issues of cultural 'fit' may prevent the *maqāṣid* from being relevant to a field or domain of inquiry. Said another way, it is crucial to assess whether conditions within a field are ripe for applying the *maqāṣid* as there may be cultural forces within a field that wholly preclude introducing the *maqāṣid* into practice.

Illustrating this challenge is the fact that biomedical discourses eschew religion. And, where religion is admitted into the conversation, for example, in evaluating patient needs, it is under the guise of a generic spirituality. A *maqāṣid*-informed bioethics firmly rooted within a religious worldview would find it hard to breach the world of clinical ethics consultation dominated by secular frameworks that appeal to common morality. Because of its lack of metaphysical commitments and cross-cultural applicability, Beauchamp and Childress' four-principle model has gained popularity across the globe.[7] To be sure, *maqāṣid*-informed bioethics could delink itself from scripture-based arguments and religious ontologies that shape the human

interests it advances. Doing so may broaden its appeal to non-Muslims but comes at the cost of removing scriptural guideposts that help orient ethicists toward Islamic norms when advising Muslim patients, providers, and policymakers.

While the *maqāṣid* are taught in some Muslim medical schools, this instruction is the exception within the Muslim world and beyond. And while arguments based on religious sources may work on a case-by-case basis when Muslim patients are involved, religiously sourced frameworks will struggle to gain acceptance as the primary modality by which ethical issues in clinical care should be resolved.

Analogously, although *maqāṣid*-based health policies and healthcare systems designed with a *maqāṣid* ethos sound alluring, advocating for such policies and systems would be exceedingly difficult in the majority of the world where the separation between religion and state is dearly valued. Moreover, even within Muslim societies, no secure foothold exists for the *maqāṣid al-Sharīᶜah* to set legislation and policy. Among Muslim countries, only Pakistan, Iran, and Saudi Arabia recognize the *Sharīᶜah* as a formal source of law. This recognition, however, is limited to *Sharīᶜah* rulings based on *uṣūl al-fiqh* which provide a religious 'check' on controversial policies and laws. Using the *maqāṣid al-Sharīᶜah* on the front end to originate policy and law, and to do so independent of *uṣūl al-fiqh*, may be perceived as exceeding the accepted limits.

Furthermore, producing change in biomedicine not only requires buy-in from end-users it also requires advocates and champions. These individuals must be both conversant with the biomedical vernacular as well as literate in Islamic moral theology because they have a dual role to play. On one side, they have to persuade Muslim stakeholders that *maqāṣid* approaches are sound and consistent with Islamic morality. On the other, they must work within biomedicine to discern where the *maqāṣid* can be successfully implemented. Beyond these functional roles, they may have to work with scholars of Islam to help them conceptualize biomedicine more fully and also

work with biomedical stakeholders to help them see the benefits of *maqāṣid* approaches.

Developing such 'bridge scholars' requires a cultural shift in education. Across the globe, the pursuit of biomedical knowledge is far separated from the pursuit of religious knowledge. This divide is further accentuated within Muslim circles as seminary curricula do not integrate the biomedical sciences and medical institutions do not teach religion. Some critical shortcomings highlighted in the preceding chapters emerge from this separate-silo situation. It behooves *maqāṣid* thinkers to develop programs that instruct individuals on the contemporary natural and social sciences alongside the practical and scholastic theological sciences. Such training would provide *maqāṣid* advocates with the literacy and skills to better address the implementation side. Moreover, such training programs can benefit researchers by equipping them with critical knowledge of the fields they need to bridge.

In summary, scholars need to address issues of culture as they seek to link *maqāṣid* and biomedicine. Contemporary biomedical culture may preclude using the *maqāṣid* in specific ways, and existing educational programs may not yet produce individuals equipped with the skills and knowledge to interface with the worlds of biomedicine and Islam effectively. Successfully integrating the *maqāṣid* within biomedicine rests on attending to these obstacles.

A Path Forward

Maqāṣid advocates herald the *maqāṣid* as a panacea to many perceived problems in extant Islamic ethical and legal deliberation. They contend that the *maqāṣid* can redress the 'tyranny of the text' whereby Islamic jurists dominate over other disciplinary experts in furnishing Islamic guidance where fiqh crowds out all other modalities of understanding Islamic morality. The *maqāṣid* are also supposed to facilitate Muslims in securing an equal footing in transnational

dialogues where human reason and secular arguments are privileged because they are accessible to rationality, do not need scriptural anchors, and prioritize common human interests. Additionally, the *maqāṣid* are thought to be a viable means by which the values and forces shaping contemporary society can be appropriately accounted for within Muslim ethical, political, and legal deliberation. While each of these posited benefits are open to debate, it is incontrovertible that they can only be obtained after the obstacles presented by the conceptual, methodological, and cultural issues outlined above are surmounted. But how can this be achieved? To begin four strategies must be employed.

Strategy One: Make the Qur'an the Primary Source of Valid Human Interests

The first strategy involves restoring the scriptural texts, specifically the Qur'an, to its central place. The human interests that the *maqāṣid* preserve must be established by revelation. As the direct communication of the Lawgiver, the Qur'an is the only reliable repository of Divine intent. Within it, the Lawgiver details the qualities and actions He approves of and which He does not. Islamic axiology must therefore ground itself within the Qur'an. Admittedly, the Sunnah demonstrates how the ideals of the Qur'an are embodied and implemented in society and also shapes our understandings of the interests. This is appropriate. However, human reason cannot admit interests that are not sourced within the Qur'an; its function is to discern and flesh out the meaning of interests validated by the Lawgiver within revelation. As noted above, using other sources as a foundation for the *maqāṣid* has resulted in ambiguity over what the interests are and unnecessarily draws the ire of theologians and jurists who consider human rationality as fallible.

Strategy Two: Conduct Multidisciplinary Analyses

The second strategy was foreshadowed above: multidisciplinary analyses are required to address conceptual, methodological, and cultural challenges hampering the integration of *maqāṣid* in society. Today, scholars working in disciplinary silos generate incomplete analyses and imperfect solutions. Instead of continuing this trend, a more holistic structure for the *maqāṣid* is furnished when multidisciplinary analyses of both scripture and society are performed. A multidisciplinary reading of the Qur'an will generate more comprehensive definitions of the interests and more complete understandings of their normative dimensions. Multidisciplinary analyses of society, its structures, and its cultural paradigms will reveal entry points and strategies for integrating *maqāṣid*-based morality within multiple spheres of human life.

Indeed, multidisciplinary teams are better positioned to solve the epistemic and methodological challenges that hamstring current *maqāṣid* and biomedicine dialogue because they can draw upon techniques and tools from various disciplines. And more complete conceptions of human interests, more comprehensive understandings of contemporary society, and better *maqāṣid*-based frameworks can only be obtained when theologians, jurists, social scientists, practitioners, and academic researchers work alongside each other. Working together is no easy feat as it will require a great investment of time and energy to develop shared conceptual vocabularies and moral visions. Yet, the pay-off will be a proverbial bridge across which deeply rooted moral values within the Islamic tradition can be conveyed and integrated into the society of today.

Producing Islamic moral knowledge is necessarily a multidisciplinary endeavor because such knowledge is relational and perceptive, and the nature of inquiry is multi-dimensional.[8] By stating that knowledge is relational, I reference that knowledge is information that connects the subjective pole of knowledge (the seeker) with the

objective pole of knowledge (the thing that one desires to know about). When declaring knowledge as perceptive, I draw attention to humans' limited capacity to discern ontological reality. As such, knowledge resides within an individual (or group) and refers to their perception of the true nature of a thing. Regarding the generation of moral knowledge being multidimensional, I note that an object of knowledge has different aspects to its reality; hence unveiling each aspect requires a different set of disciplinary tools.

To illustrate why a multidisciplinary approach is needed, let us examine the nature of inquiry and relationships between the subject and object of knowledge more closely. On one end, we have a person who seeks to make a moral assessment about an object or state of affairs that are located on the other. To do so, the person will require two different types of information, each being contingent upon the nature of the knowledge. The first information stream relates to the object/issue as it appears in present reality. Suppose the object is a piece of technology. In this case, the subject needs information about its nature, its purposes, the social implications of the technology, its limits, and the like. On the other hand, if the object is a state of affairs, then the seeker needs information about why the affairs are as they are, the ethical concerns that are driving the present conditions, what the cultural, legal, and social dimensions the issue at hand are, and other similar data. This first part of moral assessment thus relates to matters of this life and involves data from various contemporary disciplines. The second aspect of moral assessment entails analyzing whether present conditions or a future proposed state align with Islamic morality. In other words, does the technology or state of affairs advance or harm interests legitimated by the Qur'an and Sunnah. Such analysis requires scriptural knowledge.

Having identified the types of information needed, let us consider how such knowledge may be obtained. Assuming that both the object and the subject of knowledge are located in the same plane of existence, the former undergoes processes of disclosure as the latter

probes its reality using their rational and supra-rational faculties. Thus, when the subject desires to glean the 'this world' reality of the technology or state of affairs, he/she must recognize his/her own multidimensionality and that of the object of knowledge. He/she must utilize the full range of his/her capacities of discernment, including the cognitive, affective, practical, ethical, and spiritual to probe the object while simultaneously accounting for the fact that the object has social, biological, legal, cultural, and historical dimensions. The necessity of a fuller and more holistic knowing about the object/state of affairs mandates multidisciplinary analysis, as does the requirement that all human faculties of knowing be employed. The subject must possess the skills needed for such multi-dimensional investigation, or alternatively draw upon others with the requisite disciplinary expertise. Accordingly, this world-oriented knowledge is rationally derived, scientific, and is classified as *ḥuṣūlī* (attained) in Islamic epistemology.[9]

The second part of moral discernment seeks information about the afterlife benefits and harms (i.e., God's approval or disapproval) of deploying a certain technology or instantiating a state of affairs. This knowledge can only be gleaned from revelation or emerge from spiritual reflection, and it is classified as *ḥuḍūrī* (presential) in Islamic epistemology.[10] Theologians and jurists are most learned in the scriptural texts and modes of esoteric knowing, and thus positioned to provide insights into the correspondence of a particular state of affairs with God's approbation. At times, afterlife harms and benefits coincide with harms and benefits of this world, which obligates theologians and jurists to also rely on the testimony of disciplinary experts about the worldly benefits and harms of a technology or a state of affairs. Given that it is rare for a single individual to have mastery over the many different disciplines required to produce moral knowledge, working groups and team-based research should be the norm. Since *maqāṣid* research is about acquiring and generating Islamic moral knowledge, it requires a multidisciplinary approach.

An innovative approach that appears to involve both of the above strategies is the *maqāṣid* methodology outlined by Jasser Auda.[11] Auda gives priority to the Qur'an as the fountainhead of morality and advocates for multidisciplinary engagement to glean how its moral vision can be accomplished within society. To generate a more holistic approach to the field, Auda proposes a systematic approach to analyzing the Qur'an for *maqāṣid*. *Maqāṣid* frameworks, in his view, emerge from an interconnected web of meanings that undergird revelation. These webs are comprised of seven elements: concepts, objectives, values, commands, universal laws, groups, and proofs. Through multiple cycles of reflection, scholars must discern which elements specific scriptural texts speak to and how they are connected. During these cycles of reflection, primacy is given to the Qur'an. Once a provisional framework is built, support from the Sunnah is sought to make the linkages between the seven elements stronger. Auda is resolute that those building such frameworks "must have a reasonable familiarity with the entirety of the Qur'an and relevant aspects of the Sunnah, even through translation" because his methodology restores "revelation to the core of the [sic] Islamic scholarship."[12]

With a provisional framework built, contemporary society and philosophy are examined next. Auda notes that critical studies of literature and reality (i.e., the natural and social sciences as well as the humanities) are necessary for describing the problem space, and that both Islamic and non-Islamic research must be reviewed. Since enhancing "life on earth" is a primary goal of the *maqāṣid*, he argues that "this betterment is tied to an assessment of lived realities" and requires multidisciplinary research that compares how societal norms and values match up with scriptural norms and values.[13] Decrying the dichotomy between religious and secular knowledge and cognizant of the need to collaborate across fields, he broadens the definition of Islamic scholars to include "all seekers of knowledge, males and females, from all disciplinary backgrounds and at various levels and capacities, who are seeking to make theoretical and practical

contributions to any subject matter based on a dedication to the Revelation [sic] as the driver of their thoughts and approaches."[14] With the caveat that "backgrounds, specialisations and levels of expertise obviously dictate what each scholar is qualified to research, and how authoritative their opinions will be,"[15] he admits this diverse group of experts into the deliberative circle and tasks them to work collaboratively with scriptural scholars to build composite *maqāṣid* frameworks and discern their governing ethical principles. Based on these frameworks and principles, new Islamic rulings, policies, and laws can be generated which live out Islamic morals in contemporary society. His provisional methodology thus adopts multidisciplinary engagement with reality while reaffirming that the *maqāṣid* must emerge from the Qur'an.

In addition to Auda, Adi Setia, a researcher working at the interface of Islam, science, and contemporary society, also recommends multidisciplinary *maqāṣid* research. He exhorts Islamic legists to work together with scholars of philosophy and of contemporary science to re-apply a *kalām jadīd* dialectical approach (a renewed theological dialectics), where modern terms and concepts are "unpacked" so that their undergirding values are revealed. At the same time, the institutions through which these concepts are operationalized in society should be "structurally audit[ed]" so that links between moral values and social structures are made more explicit.[16] This process would yield a more comprehensive and holistic understanding of the contemporary ethical problem-space. Once societal values, norms, and structures are better understood, Islamic jurists and theologians are better positioned to intervene in society with ethical guidelines, rulings, and frameworks drawn from revelation that precisely address specific problem-spaces.

Strategy Three: Adopt Humility in Dialogue

The third strategy is intimately connected to the second: as multi-

disciplinary teams discern the *maqāṣid* and identify how they may be achieved within society, humility in dialogue must be cultivated. All parties involved must recognize that their knowledge is limited, their disciplinary tools and methodologies have intrinsic weaknesses, and that a comprehensive understanding of reality is beyond their grasp. Cognizance of these facts facilitates a dialogue where scholars: (i) foreground limitations in their data and analyses, thus being open to the legitimacy of other's vantage-points and data sources; (ii) make statements about the Lawgiver's intent bearing in mind that a plurality of views is legitimate; and (iii) design frameworks and tools that attend to the needs of end-users without claiming that the resulting solutions are Islamic moral obligations or the final word. Such dialogue may even yield ethical guidelines that more authentically encapsulate the Islamic worldview because epistemic humility requires that no single disciplinary expert overreach to claim certainty nor overstep by making assertions that cannot be supported by evidence. In my view, an open-minded, multidisciplinary dialogue will prove invaluable in addressing the conceptual ambiguities, methodological challenges, and cultural issues that problematize the adoption of *maqāṣid* because any resulting truth claims will be made cautiously and the inherent shortcomings of posited solutions will be made transparent.

Strategy Four: Complement but do not Supplant Fiqh

The fourth and final strategy is to use *maqāṣid* analyses as a supplement to, but not a replacement for, fiqh. Arguably, the science of *uṣūl al-fiqh* is the most sophisticated Islamic science. Its techniques result from hundreds of years of scholarly discourse over theory and method, and it has been operationalized in the practice of thousands of jurists and legists. The resulting output of this science (i.e., fiqh rulings) have established centuries of ethico-legal precedent.

While some argue that fiqh has fossilized to the point that it inadequately meets the demands of a changing world, it is noteworthy that fiqh manuals record minority and majority views across legal schools and *uṣūl al-fiqh* considers each of these opinions as morally actionable. Hence, the inherited canon allows for a wide orthopraxy where many diverse practices are considered normative. Given that *maqāṣid* theories and frameworks remain under construction, *maqāṣid*-based rulings are, at best, tentative conclusions, and discarding established fiqh is mistaken. *Maqāṣid*-based methods for discerning law would devalue the traditionally accepted four sources of Islamic law (Qur'an, Sunnah, *ijmā*ᶜ, and *qiyās*) as means for discerning Divine will.[17] The role of revelation as a direct guide to morality, scholarly consensus as a reliable indicant of Islamic norms, and analogical reasoning as a method for extending revelation-based rulings to new scenarios would depreciate in favor of partially complete *maqāṣid* frameworks that are not wedded to scripture.

Such a departure would be risky for, according to the renowned Islamic jurist Shaykh Abdullah Bin Bayyah, *uṣūl al-fiqh* "guarantees the correct usage and application of the higher objectives"[18] because that science ensures that *maqāṣid*-based rulings are not based on subjective, extra-textual, human interests. *Uṣūl al-fiqh* also provides an epistemic register through which scriptural and non-scriptural evidences can be weighed, while *maqāṣid* theories do not have such sophisticated balancing mechanisms.[19] Additionally, fiqh rulings are rigorously vetted and mediated through a community of trained jurists and thus are authoritative representations of Islamic morality. The same cannot be said for *maqāṣid*-based rulings because the science still requires elucidation in order for formal training programs and a community of practice to be set up. In short, in areas of established fiqh, fiqh rulings should not be overturned based on a *maqāṣid* analysis; rather some rulings could be preferred over others because they align with such analyses. Accordingly, the *maqāṣid* should serve as adjuncts to established fiqh rulings. However, when addressing

questions where legal precedents do not exist—as is the case in areas requiring fresh ijtihad—*uṣūl al-fiqh* and *maqāṣid al-Sharīᶜah* analyses could be carried out in parallel to yield convergent ethico-legal rulings. In this way, *maqāṣid* frameworks complement *uṣūl al-fiqh* analyses as well as help fine-tune Islamic moral assessment.

Final Remarks

Frameworks built upon the *maqāṣid al-Sharīᶜah* have the potential to revitalize Islamic ethical and legal scholarship. Fully capitalizing on this potential, however, requires that: (i) the Qur'an is used to identify legitimate human interests that must be preserved; (ii) multidisciplinary analyses of both scripture and society are conducted so that holistic understandings of Islamic morality and the contemporary problem-space emerge; (iii) humble dialogue between scholars of the text and the context takes place such that assessments are made in full cognizance of the limitations of particular data sources and analytic methods; and (iv) *maqāṣid*-based analyses complement, but do not supplant, fiqh. Besides these overall benefits for Islamic thought, scholarship at the intersection of the *maqāṣid* and biomedicine will advance as these four strategies are employed. A better conceptualization of the human interests and the *maqāṣid* will result from giving priority to the Qur'an and multidisciplinary analyses of scripture. Methodological challenges are more likely to be overcome when scholars from different disciplines engage in humble dialogue and draw upon resources from each other's fields and when *maqāṣid*-based analyses do not have to do the work of fiqh. Similarly, cultural issues will be better navigated when holistic, multidimensional understandings of the problem-space emerge from multidisciplinary research.

I began this book by seeking to address several questions at the heart of Islam and biomedicine discourses: How and why might the *maqāṣid al-Sharīᶜah* be relevant to contemporary biomedicine? What

do theories of the *maqāṣid al-Sharīᶜah* have to say about individual health and societal well-being? How might values and interests represented by the *maqāṣid* inform healthcare practices and policies? Can *maqāṣid* frameworks furnish an Islamic approach to clinical ethics decision-making? Rather than providing definitive, comprehensive answers to these questions, the preceding exploration has yielded several possibilities while highlighting shortcomings within the extant literature that tackles these questions. Importantly this book has provided the necessary foundations for deeper engagement between the *maqāṣid* and biomedicine. Consequently, the path forward has been mapped out, and it is up to us as stakeholders to undertake the journey through strategic scholarship that helps us reach the higher objective of bettering human lives by bridging *maqāṣid* and biomedicine.

In closing all praise is due to God and He knows best.

ENDNOTES

Introduction

1. Using the *maqāṣid al-Sharīʿah* as grounds for developing public policy, as well as reorienting current polices toward Islamic goals is an ongoing enterprise within the Muslim world, particularly in Malaysia. While public media document this trend, explicit references to the *maqāṣid* may be absent in official policies and documents. An interesting case study of the push to align penal codes with Islamic law and possibly discard colonial law is described in Ibrahim Zein, "*Maqāṣid* and the Codification of Islamic Penal Rules: The Sudanese Experiment," in *Maqāṣid al-Sharīʿah: Explorations and Implications*, ed. Mohamed El-Tahir El-Mesawi (Kuala Lumpur: Islamic Books Trust, 2018), pp.243–80; similarly, the reader is directed to a detailed study addressing the field of public policy from a *maqāṣid* perspective in Basma I. Abdelgafar, *Public Policy: Beyond Traditional Jurisprudence: A Maqāṣid Approach* (London: IIIT, 2018); Mushtak Parker, "A Unique 'Budget of Inclusion'," *New Straits Times*, October 29, 2017, accessed June 29, 2022; "Policies to Utilise Maqasid Syariah," *The Malaysian Voice*, April 24, 2022, accessed June 29, 2022; and Bernama, "Maqasid Shariah Helps to Uplift Economy of Muslims in Malaysia," *Malay Mail*, August 3, 2017, accessed June 29, 2022, https://www.malaymail.com/news/malaysia/2017/08/03/maqasid-shariah-helps-to-uplift-economy-of-muslims-in-malaysia/1435209.
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5. For recent surveys of the field in English the reader is directed to Mohamed El-Tahir El-Mesawi (ed.), *Maqāṣid al-Sharīᶜah: Explorations and Implications* (Kuala Lumpur: Islamic Books Trust, 2018); and Idris Nassery et al. (eds.), *The Objectives of Islamic Law: The Promises and Challenges of the Maqāṣid al-Sharīᶜa* (Lanham, MD: Lexington Books, 2018).
6. The term biomedicine here refers to social structures, processes, and bodies of knowledge related to the biomedical enterprise within society including the biological sciences, healthcare delivery, health policy, biolaw, and others. I elaborate on my specific usage of the term in Chapter 1.
7. The Islamicization of the Sciences project was/is an intellectual response to the secularization of the academic disciplines and perceived schism between so-called 'religious' and 'worldly' knowledge. It began as a topic of discussion at conferences in the Muslim world in 1970s, and launched into a full project of curricular reform and institution-building spearheaded by many scholars and institutions including Ismail Faruqi, Syed Naquib al-Attas, Taha Jabir al-Alwani and the IIIT. For a concise review, see A. Rashid Moten, "Methodology of Islamization of Knowledge," *The American Journal of Islamic Social Sciences* 7(2) (September 1990): 161–75; and Louay Safi, "The Quest for Islamic Methodology: The Islamization of Knowledge Project in Its Second Decade," *American Journal of Islamic Social Sciences* 10(1) (1993): 23–48. For a critique, see Feryad Hussain and Anke Iman Bouzenita, "Squaring the Circle: A Critique of the Islamisation of the Human Sciences Project," *Islamic Studies* 50(3/4) (2011): 347–64.
8. The Islamic finance and halal food industry are two particularly prominent examples of such movements that seek footholds within non-Muslim societies so that Muslims can live out "Shariᶜah-complaint" lives.
9. Much of the English-language work in this area has been published by the International Institute of Islamic Thought.
10. Nassery et al., *The Objectives of Islamic Law*; and El-Mesawi, *Maqāṣid al-Sharīᶜah: Explorations and Implications*.

11. Shaikh Mohd Saifuddeen et al., "Maqasid al-Shariah as a Complementary Framework to Conventional Bioethics," *Science and Engineering Ethics* 20(2) (2014): 317–27; Omar Hasan Kasule, "Medical Ethics from Maqasid Al Shariʿat," *Arab Journal of Psychiatry* 15(2) (2004): 75; Tarik Abdul Razak and Hashi Abdurezak Abdulahi, "Incorporating Moral Values and Maqasid al-Syariʿah into Medical and Healthcare Practices," *IIUM Medical Journal Malaysia* 15(2) (2016): 1–2; and Anke Bouzenita, "Maqasid and Related Islamic Legal Concepts on Current Bioethical Issues: Critical Reflections," in *Maqāṣid al-Sharīʿah: Explorations and Implications*, ed. Mohamed El-Tahir El-Mesawi (Kuala Lumpur: Islamic Books Trust, 2018), pp.281–310. Sharmin Islam, *Ethics of Assisted Reproductive Medicine: A Comparative Study of Western Secular and Islamic Bioethics* (London: IIIT, 2013).
12. Gary S. Belkin, "Brain Death and The Historical Understanding of Bioethics," *Journal of the History of Medicine and Allied Sciences* 58(3) (2003): 325–61; Stuart J. Youngner et al. (eds.), *The Definition of Death: Contemporary Controversies* (Baltimore, MD: Johns Hopkins University Press, 2002); Jenny Schreiber, "Biomedicine as Global Assemblage: The Malay Muslim Account of Total Brain Failure," *Die Welt des Islams* 55(3–4) (2015): 312–47; and Paul A. Byrne et al., "Brain Death—The Patient, the Physician, and Society," in *Beyond Brain Death*, eds. Michael Potts, Paul A. Byrne, and Richard G. Nilges (Dordrecht: Springer, 2000), pp.21–89.
13. Aasim I. Padela et al., "Producing Parenthood: Islamic Bioethical Perspectives & Normative Implications," *The New Bioethics* 26(1) (2020): 17–37; Morgan Clarke, *Islam and New Kinship: Reproductive Technology and the Shariah in Lebanon* (New York: Berghahn Books, 2009); and France Winddance Twine, *Outsourcing the Womb: Race, Class and Gestational Surrogacy in a Global Market* (New York: Routledge, 2015).
14. Michel Foucault, *The Will to Knowledge: The History of Sexuality Volume* 1, trans. by Robert Hurley (New York: Pantheon Books, 1978).
15. The Joint Commission on Accreditation of Healthcare Organizations in the United States, for example, advocates for the spiritual assessment of patients in order to provide high-quality healthcare.
16. One example of this is that the United Nations Educational, Scientific and Cultural Organization (UNESCO) sponsors bioethics conferences that take on inter-religious and multi-faith perspectives.
17. Such collaborations in the United States context are witnessed by the White House Office of Faith-Based and Neighborhood Partnerships, and the Health and Human Services Center for Faith and Opportunity Initiatives, among others.
18. I significantly complicate the relationship between religion and contemporary healthcare in Chapters 6 and 7. The reality is not as rosy as my statement here seems. Religious beliefs, values, and identity are marginalized within biomedical discourses and constrained within contemporary healthcare delivery.

1. Biomedicine and Contemporary Healthcare: Delineating the Problem-Space and Context

1. Thoman Kuhn, an American physicist and philosopher, popularized the notion of paradigm shifts marking the history of scientific progress. Paradigms are a distinct set of concepts or thought patterns, including theories, research methods, postulates, and standards that help constitute a field.
2. Ilana Löwy, "Historiography of Biomedicine: 'Bio,' 'Medicine,' and In Between," *Isis* 102(1) (2011): 116–22, https://doi.org/10.1086/658661.
3. Sean Valles, "Philosophy of Biomedicine," April 9, 2020, *The Stanford Encyclopedia of Philosophy*, ed. Edward N. Zalta (Summer 2020 ed.), https://plato.stanford.edu/archives/sum2020/entries/biomedicine/.
4. Robin W. Scheffler and Bruno J. Strasser, "Biomedical Sciences, History and Sociology of," in *International Encyclopedia of the Social & Behavioral Sciences*, ed. James D. Wright, 26 vols. (2nd ed. Amsterdam, NE: Elsevier, 2015), https://doi.org/10.1016/B978-0-08-097086-8.85045-X.
5. As I will discuss later on in this book, biomedicine has globalized, and notions of 'Western' and 'Eastern' medical models may no longer be applicable. My usage of the term 'Western' here, however, is apropos because: (i) it represents the location of where the term was developed; (ii) it represents a link to European intellectual movements that underpin the philosophical and methodological commitments of biomedicine; and (iii) it represents a link to the political and economic circumstances within the United States and Western Europe that allowed for the dominance of healthcare by the biomedical model.
6. Notably the 'Western' medical schools are divided into allopathic (M.D.) and osteopathic (D.O.) training programs. While there are philosophical differences underlying osteopathy and allopathy, whereby osteopathy-based medical schools teach their students techniques of physical manipulation and massage as adjunctive to clinical treatment while allopathic medical schools do not, osteopathy-based medical care has largely been subsumed under the umbrella of biomedicine. For example, within the United States, there is hardly a difference between the clinical practices of a doctor of osteopathy (D.O.) and a doctor of allopathic medicine (M.D.) because residency training programs and clinical specialty board certifications increasingly accept graduates from either type of medical school. The residency programs and board certification exams serve to 'flatten' the practices of these clinicians so that they are increasingly indistinguishable from each other. Indeed, the philosophical underpinnings of osteopathy that considered physical manipulation of the body as a means to restore balance are no longer routinely taught as an alternative paradigm upon which physicians can base their medical practices.
7. Muna Ali, "The 'Bio' in Biomedicine: Evolution, Assumptions, and Ethical Implications," *Islamic Perspectives on the Principles of Biomedical Ethics: Muslim Religious*

Scholars and Biomedical Scientists in Face-to-Face Dialogue with Western Bioethicists, ed. Mohammed Ghaly (London: World Scientific Publishing/Imperial College Press, 2018), pp.41–67.

8. One could argue that biomedicine is also applied to the care of animals (veterinary medicine) and would be applied to organisms discovered elsewhere in the universe (exobiology). Such discussions are beyond the scope of this book.
9. Indeed, dedicated institutes and centers for translational research are found at many academic medical centers in the United States. These centers/institutes are dedicated to furthering the biomedical model of research and experimentation and are sponsored by the leading funder of health research in the United States, the National Institutes of Health. See Marco Zarbin, "What Constitutes Translational Research? Implications for the Scope of *Translational Vision Science and Technology*," *Translational Vision Science & Technology* 9(8) (July 2020): 22, https://doi.org/10.1167/tvst.9.8.22.
10. Nancy Krieger, *Epidemiology and the People's Health: Theory and Context* (New York: Oxford University Press, 2011); and Valles, "Philosophy of Biomedicine."
11. For more analysis related to the practice of medicine and the four causes, see Jeffrey P. Bishop, *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying* (Notre Dame, IN: University of Notre Dame Press, 2011), p.365.
12. Ayurvedic medicine is a traditional approach to health rooted in Hinduism and older Vedic worldviews that aims to maintain holistic balance between the body, mind, and spirit in order to obtain complete well-being. The therapeutics offered in this system include medicinal herbs, mental and spiritual exercises, surgical treatments, physical manipulation, and dietary modifications.
13. Diseases are, at least in part, socio-culturally constructed. A much-discussed example is the 'disease' of idiopathic short stature, which is identified when an individual has a height below two standard deviations of the mean age-adjusted height in society, and this much lower-than-average height cannot be explained by a biological cause. Biomedicine not only labels this malady based on assumptions about the normality of bodily height, but it also provides a cure for the 'disease' through hormonal treatments. Other exemplars of the socio-cultural construction of disease include infertility and congenital deafness. Implicit to labeling these conditions as diseases is an assumption about the normative body, and fueling cultural expectations that these conditions be considered disease states are biotechnological remedies that can be had. While beyond the scope of this book, analyzing Islamic theological concepts related to disease and cure and the normative body and how they match up with biomedical models would provide a robust Islamic critique of contemporary biomedicine and healthcare.
14. Ali, "The 'Bio' in Biomedicine."
15. Arthur Kleinman, *Writing at the Margin: Discourse Between Anthropology and Medicine* (Berkeley, CA: University of California Press, 1995), p.30.

16. Valles, "Philosophy of Biomedicine."
17. Kleinman, *Writing at the Margin*, p.32.
18. The term biopower was coined by French philosopher Michel Foucault and refers to the practice by which states exert control over and subjugate their populations.
19. To be clear, I am not saying that there was insufficient cause and justification to enact social distancing measures. Preventive health measures were prudent and justified as precaution against a disease that was spreading rapidly and had high mortality rates. Indeed, as an emergency medicine clinician, I was on the frontlines witnessing the morbidity and mortality wrought by COVID-19, and as an Islamic bioethicist, I opined that such measures were justified. My point, however, is that exerting biopower does not require incontrovertible data, and in light of this, biomedicine is often used by political actors to shape the social life of citizens.
20. Kleinman, *Writing at the Margin*.
21. John Z. Sadler et al. apply this definition to medicalization, I have added the bio to the term; see John Z. Sadler et al., "Can Medicalization be Good? Situating Medicalization within Bioethics," *Theoretical Medicine and Bioethics* 30 (2009): 411, https://doi.org/10.1007/s11017-009-9122-4.
22. Ibid.
23. Centers for Disease Control and Prevention, "Health in All Policies" (Last modified June 9, 2016), accessed December 5, 2022, https://www.cdc.gov/policy/hiap/index.html; and_American Public Health Association, "Health in All Policies," accessed December 5, 2022.
24. Raymond De Vries, "The Uses and Abuses of Moral Theory in Bioethics," *Ethical Theory and Moral Practice* 14(4) (2011): 419–30, https://doi.org/10.1007/s10677-011-9290-y; and Raymond De Vries and Leslie Rott, "Bioethics as Missionary Work: The Export of Western Ethics to Developing Countries," in *Bioethics Around the Globe*, ed. Catherine Myser (Oxford: Oxford University Press, 2011), pp.3–18.
25. Here, too, I subsume osteopathy under allopathy as it has become conventional when referring to contemporary healthcare delivery. Illustratively, the World Health Organization defines allopathic medicine as "the broad category of medical practice that is sometimes called Western medicine, biomedicine, evidence-based medicine, or modern medicine." See World Health Organization, *Legal Status of Traditional Medicine and Complementary/Alternative Medicine: A Worldwide Review* (Geneva: World Health Organization, 2001), p.1, https://www.who.int/publications/i/item/WHO-EDM-TRM-2001.2.
26. Stephen Jay Gould, "Nonoverlapping Magisteria," *Natural History* 106(2) (March 1997): 16–22, https://doi.org/10.53763/fag.2014.11.95.
27. Arthur Kleinman, *Patients and Healers in the Context of Culture: An Exploration of the Borderland between Anthropology, Medicine, and Psychiatry* (Berkeley, CA: University of California Press, 1980).

28. Aasim I. Padela et al., "The Types of Trust Involved in American Muslim Healthcare Decisions: An Exploratory Qualitative Study," *Journal of Religion and Health* 56(4) (March 2017): 1478–88, https://doi.org/10.1007/s10943-017-0387-z.
29. Kleinman, *Patients and Healers*.
30. Irving K. Zola, "Studying the Decision to See a Doctor," in *Psychosocial Aspects of Physical Illness*, ed. Z.J. Lipowski (Basel: Karger, 1972), vol. 8, pp.216–36.

2. An Overview of Maqāṣid al-Sharīah Frameworks: Describing the Tools

1. I adopt Prof. Mohamed Fadel's usage of the English term moral theology to refer to the Islamic science of *uṣūl al-fiqh*. As Fadel notes, in so far as *uṣūl al-fiqh* is concerned with the scriptural sources of moral obligation, the processes of moral assessment, and moral epistemology it is a moral science. And since *uṣūl al-fiqh* is primarily concerned with how God judges human acts and strives to reach the truth regarding moral propositions, it is a theological discipline. Consequently, the mapping of terms is apropos even if not precise. See Mohamed Fadel, "The True, the Good and the Reasonable: The Theological and Ethical Roots of Public Reason in Islamic Law," *Canadian Journal of Law and Jurisprudence* 21(1) (January 2008): 5–69, http://ssrn.com/abstract=1085347.
2. The relationship between the *maqāṣid* and *uṣūl al-fiqh* is subject to differing views. Some scholars view the *maqāṣid* as a subgenre within *uṣūl al-fiqh* while others consider it to be a parallel science that furnishes Islamic ethico-legal rulings independently. I describe these views and tensions in the last part of this chapter.
3. Muhammed al-Tahir Ibn Ashur, *Ibn Ashur: Treatise on Maqāṣid al-Shariʿah*, trans. Mohamed El-Tahir El-Mesawi (London: IIIT, 2006); Ahmad al-Raysuni, *Imam al-Shatibi's Theory of the Higher Objectives and Intents of Islamic Law*, trans. Nancy Roberts (London: IIIT, 2005); and Ibrāhīm ibn Mūsā Abū Isḥāq al-Shāṭibī, *The Reconciliation of the Fundamentals of Islamic Law, Vol 2: Al-Muwāfaqāt fī Usūl al-Sharīʿa*, trans. Imran Ahsan Khan Nyazee (1st ed., Reading: Garnet Publishing, 2011).
4. The Qur'an and Sunnah are considered complementary parts of the revelation (*waḥy*). The former represents the literal word of God transmitted through angel Gabriel to the Prophet Muhammad, while the latter represents the sayings, actions, and tacit approvals of the Prophet. For this reason some scholars refer to the Qur'an as *waḥy matlū* (the recited revelation) and the Sunnah as *waḥy ghayr matlū* (revelation that is not recited).
5. For discussions about such matters, see Muhammad bin Hamid al-Ghazali, *al-Mustaṣfā min ʿIlm al-Uṣūl*, 4 vols., ed. Hamza bin Zuhair Hafiz (Madinah: Dar al-Nashr, 1993); Anver M. Emon, *Islamic Natural Law Theories* (Oxford: Oxford University Press, 2010); and Subhi Rajab Mahmasani, *Falsafat al-Tashrī fī al-Islām: The Philosophy of Jurisprudence in Islam* (Leiden: E.J. Brill, 1961).

6. Al-Raysuni, *Imam al-Shatibi's Theory*.
7. Ibid., p. xxiii.
8. Ibid.; and Mohammad Hashim Kamali, *Maqāṣid al-Sharīʿah, Ijtihad and Civilisational Renewal* (London: IIIT, 2012).
9. Kamali, *Maqāṣid Al-Sharīʿah, Ijtihad and Civilisational Renewal*.
10. Khalil Abdur-Rashid et al., "Lifting the Veil: A Typological Survey of the Methodological Features of Islamic Ethical Reasoning on Biomedical Issues," *Theoretical Medicine and Bioethics* 34(2) (1May 2013): 89, https://doi.org/10.1007/s11017-013-9251-7.
11. Kamali, *Maqāṣid Al-Sharīʿah, Ijtihad and Civilisational Renewal*, p.5.
12. In legal theory, several divisions exist. For example, *maṣaliḥ* can be categorized in terms of scope as general/communal (*ʿāmmah*) or particular/specific (*khāṣṣah*). Another schema considers their grounding within scripture. This classification schema involves the terms *muʿtabarah*, *mursalah*, or *mulghāh*, where *al-muʿtabarah* refers to public interests that are expressly upheld by scripture, *al-maṣlaḥah al-mursalah* refer to interests that are not found within the Qur'an and Sunnah, and as such Islamic legists disagree over whether they are sufficient bases for moral duties, and *mulghāh* interests are those that have been rejected or otherwise run counter to scriptural source-texts.
13. Al-Raysuni, *Imam al-Shatibi's Theory*, p. xxviii.
14. Jasser Auda, *Maqasid al-Shariah as Philosophy of Islamic Law: A Systems Approach.* (London: IIIT, 2008); and Jasser Auda, *Maqāṣid al-Sharīʿah: A Beginner's Guide* (London: IIIT, 2008).
15. Al-Raysuni, *Imam al-Shatibi's Theory*; and Kamali, *Maqāṣid Al-Sharīʿah, Ijtihad and Civilisational Renewal.*
16. Kamali, *Maqāṣid al-Sharīʿah, Ijtihad and Civilisational Renewal.*
17. This permission is based on Qur'anic scripts and Prophetic precedent.
18. Kamali, *Maqāṣid al-Sharīʿah, Ijtihad and Civilisational Renewal*, p.20; and Auda, *Maqasid al-Shariah as Philosophy*, p.22.
19. Al-Raysuni, *Imam al-Shatibi's Theory*, p.281.
20. Ibid., p.282.
21. The Islamic schools of law are not aligned according to whether the use of *maṣlaḥah mursalah* is valid. The Malikī school champions this method for generating law while the other Sunni schools see it as too decoupled from the scriptural sources to ground Islamic rulings.
22. Kamali, *Maqāṣid al-Sharīʿah, Ijtihad and Civilisational Renewal.*
23. Al-Raysuni, *Imam al-Shatibi's Theory*, p.285.
24. Gamal Eldin Attia, *Towards Realization of the Higher Intents of Islamic Law: Maqāṣid al-Shariʿah, A Functional Approach* (Herndon, VA: IIIT, 2007).

25. Gamal Eldin Attia (b. 1928 CE) is an Islamic legal theorist with a doctoral degree in law from the University of Geneva. He has written an extensive treatise, *Nahwa Taf'il Maqasid al-Shari'ah* (*Towards Realization of the Higher Intents of Islamic Law: Maqāṣid al-Sharī'ah, A Functional Approach*) which revises and extends the *maqāṣid al-sharī'ah* to incorporate the human, social, and physical sciences.
26. Attia, *Towards Realization*, p.11.
27. Ibid.
28. Al-Shāṭibī, *The Reconciliation of the Fundamentals of Islamic Law*, p.9.
29. Ibid., p.10.
30. Ibid., p.13.
31. Al-Raysuni, *Imam al-Shatibi's Theory*.
32. Al-Shāṭibī, *The Reconciliation of the Fundamentals of Islamic Law*.
33. In my reading, a third responsibility, at times, is separated out as well, maintaining the existence of the interest. However, one could assert that maintenance is implicit to both establishing and defending the interest.
34. Al-Shāṭibī, *The Reconciliation of the Fundamentals of Islamic Law*, p.14.
35. Ibid.
36. Attia, *Towards Realization*. Although al-Shatibi considers the preservation of religion to be at the top of the hierarchy, other scholars contend that the preservation of life is the highest essential objective. I will address this debate in Chapter 7: Preserving Life or Preserving Religion? The Highest Order Objective in Healthcare.
37. Attia, *Towards Realization*; and al-Raysuni, *Imam al-Shatibi's Theory*.
38. Auda, *Maqāṣid al-Sharī'ah: A Beginner's Guide*; and al-Shāṭibī, *The Reconciliation of the Fundamentals of Islamic Law*.
39. Attia, *Towards Realization*.
40. Ibid.
41. Qur'an (5:88)
42. Attia, *Towards Realization*.
43. Ibid.
44. Ibid.
45. These requirements are discussed in detail in Chapter 3.
46. Attia, *Towards Realization*.
47. Ibid., p.120.
48. Ibid., p.121.
49. Ibid., p.122.
50. Imran Ahsan Khan Nyazee, *Theories of Islamic Law* (Islamabad: Islamic Research Institute, 2002), pp.195–230.
51. Mohammad A. Abderrazzaq, "The Revival and Evolution of *Maqāṣid* Thought: From al-Shatibi to Ibn 'Âshūr and the Contemporary *Maqāṣid* Movement," PhD dissertation, University of Michigan, 2017, pp.262–94.

52. Rumee Ahmed, "Which Comes First, the *Maqāṣid* or the *Sharīᶜa*?" in *The Objectives of Islamic Law: The Promises and Challenges of the Maqāṣid al-Sharīᶜa*, ed. Idris Nassery, Rumee Ahmed, and Muna Tatari (London: Rowman and Littlefield, 2018), pp.242–43.
53. Çefli Ademi, "The Relationship between *Maqāṣid al-Sharīᶜah* and *Uṣūl al-Fiqh*," in *The Objectives of Islamic Law: The Promises and Challenges of the Maqāṣid al-Sharīᶜa*, ed. Idris Nassery, Rumee Ahmed, and Muna Tatari (London: Rowman and Littlefield, 2018).
54. Mohammad Hashim Kamali, "Goals and Purposes *Maqāṣid al-Sharīᶜah*: Methodological Perspectives," in *The Objectives of Islamic Law: The Promises and Challenges of the Maqāṣid al-Sharīᶜa*, ed. Idris Nassery, Rumee Ahmed, and Muna Tatari (London: Rowman and Littlefield, 2018), p.8.

3. A Maqāṣid-Based View of Human Health: Identifying the Goal(s)

1. This chapter draws from a previously published article of mine, Aasim I. Padela, "The Essential Dimensions of Health According to the Maqasid al-Shariᶜah Frameworks of Abu Ishaq al-Shatibi and Jamal-al-Din-ᶜAtiyah," *IIUM Medical Journal Malaysia* 17(1) (2018): 49–58, https://doi.org/10.31436/imjm.v17i1.1035.
2. World Health Organization, "Constitution," (n.d.), accessed December 5, 2022, https://www.who.int/about/governance/constitution.
3. World Health Organization (Regional Office for South-East Asia), *Spiritual Aspects of Health.* (Geneva: World Health Organization, 1984), accessed December 5, 2022, https://apps.who.int/iris/handle/10665/127378.
4. World Health Organization, "Palliative Care," accessed December 5, 2022, https://www.who.int/news-room/fact-sheets/detail/palliative-care.
5. Ali Ibn Al-Husayn ibn Hindu, *The Key to Medicine and a Guide for Students*, trans. Aida Tibi (Reading: Garnet Publishing, 2011), p.15.
6. Jasser Auda, *Maqasid al-Shariah as Philosophy of Islamic Law: A Systems Approach* (London: IIIT, 2008); and Ahmad al-Raysuni, *Imam al-Shatibi's Theory of the Higher Objectives and Intents of Islamic Law*, trans. Nancy Roberts (Herndon, VA: IIIT, 2005).
7. Gamal Eldin Attia, *Towards Realization of the Higher Intents of Islamic Law: Maqāṣid al-Shariᶜah, A Functional Approach* (Herndon, VA: IIIT, 2007).
8. Al-Raysuni, *Imam al-Shatibi's Theory.*
9. Prof. Sherman Jackson, a contemporary Islamic legal historian and King Faisal Chair in Islamic Thought and Culture at the University of Southern California, critiques this circumscribed notion of preservation of intellect. In his view, and as we will see Prof. Attia's, the protection of this rational faculty, which in many ways defines human nature, demands working against intellectual domination and cultivation of

intellect. See Sherman A. Jackson, "Apprehending and Concretizing the *Maqāṣid al-Sharīʿah* in the Modern World," in *Maqāṣid al-Sharīʿah: Explorations and Implications*, ed. Mohamed El-Tahir El-Mesawi (Kuala Lumpur: Islamic Books Trust, 2018), pp.95–120.

10. Attia, *Towards Realization*, p.119.
11. Ibid.
12. Ibid.
13. Ibid., p.118.
14. By consideration of the mind, Attia is referring to considering the mind within the category of human interests that must be protected and preserved.
15. Al-Raysuni, *Imam al-Shatibi's Theory*, p.141.
16. Ibid., p.138
17. I will discuss such usage in greater detail in Chapter 4.
18. Ahmed Ragab, *The Medieval Islamic Hospital: Medicine, Religion, and Charity* (Cambridge: Cambridge University Press, 2015).
19. Sridhar Venkatapuram, "Health Disparities and the Social Determinants of Health: Ethical and Social Justice Issues," in *The Oxford Handbook of Public Health Ethics*, ed. Anna C. Mastroianni, Jeffrey P. Kahn, and Nancy E. Kass (Oxford: Oxford University Press, 2019), pp.266–76; Richard C. Palmer et al., "Social Determinants of Health: Future Directions for Health Disparities Research," *American Journal of Public Health* 109(S1) (January 2019): S70–S71, https://doi.org/10.2105/AJPH.2019.304964; and Orielle Solar and Alec Irwin, *A Conceptual Framework for Action on the Social Determinants of Health* (Geneva: World Health Organization, 2010).
20. J. Michael McGinnis et al., "The Case for More Active Policy Attention to Health Promotion," *Health Affairs* 21(2) (March/April 2002): 78–93, https://doi.org/10.1377/hlthaff.21.2.78; Laura McGovern et al., "Health Policy Brief: The Relative Contribution of Multiple Determinants to Health Outcomes," *Health Affairs* (August 21, 2014), https://www.healthaffairs.org/do/10.1377/hpb20140821.404487/; and Paula Braveman et al., "The Social Determinants of Health: Coming of Age," *Annual Review of Public Health* 32 (2011): 381–98, https://doi.org/10.1146/annurev-publhealth-031210-101218.

4. A Maqāṣid-Based Health Policy Agenda: Structuring Society to Achieve the Goal(s)

1. Gamal Eldin Attia, *Towards Realization of the Higher Intents of Islamic Law: Maqāṣid al-Shariʿah, A Functional Approach* (Herndon, VA: IIIT, 2007).
2. A. Kevin Reinhart, "Islamic Law as Islamic Ethics," *The Journal of Religious Ethics* 11(2) (Fall 1983): 186–203.

3. Ahmad Syukan Baharuddin et al., "An Appraisal of Maqāsid Al-Shariʿah Classic and Recent Literature: Systematic Analysis," *Library Philosophy and Practice* (2019), https://digitalcommons.unl.edu/libphilprac/3730.
4. Abul Fadl Mohsin Ebrahim, "Vaccination in the Context of *Al-Maqasid Al-Shariʿah*: (Objectives of Divine Law) and Islamic Medical Jurisprudence," *Arabian Journal of Business and Management Review* (Oman Chapter) 3(9) (May 2014): 44–52, https://doi.org/10.12816/0016499; Musa Mohd Nordin, "Immunisation from the Perspective of Maqasid Shariʿah," *Bangladesh Journal of Medical Science* 15(2) (August 10, 2016): 151–53; Asmara Malik et al., "Acceptance of COVID-19 Vaccine in Pakistan among Health Care Workers," *PLoS ONE* 16(9) (September 2021), e0257237, https://doi.org/10.1371/journal.pone.0257237; Musa Mohd Nordin et al. "Immunization from the Perspective of Maqasid Sharʿiah," *Encyclopedia of Islamic Medical Ethics—Part VII Maqasid al-Shariʿah and Medical Jurisprudence and Bioethics* (Amman: Jordan Society for Islamic Medical Sciences, February 2022); and Adi Jafar et al., "COVID-19 Vaccine Hesitancy in Malaysia: Exploring Factors and Identifying Highly Vulnerable Groups," *PLoS One* 17(7) (July 2022), e0270868, https://doi.org/10.1371/journal.pone.0270868.
5. Cf. Aldous Huxley's *Brave New World* (London: Chatto & Windus, 1932).
6. Ahmad al-Raysuni, *Imam al-Shatibi's Theory of the Higher Objectives and Intents of Islamic Law*, trans. Nancy Roberts (London: IIIT, 2005).
7. Imran Ahsan Khan Nyazee, *Theories of Islamic Law* (Islamabad: Islamic Research Institute, 2002).
8. Ibrāhīm ibn Mūsā Abū Isḥāq al-Shāṭibī, *The Reconciliation of the Fundamentals of Islamic Law, Vol. 2: Al-Muwāfaqāt fī Usūl al-Shariʿa*, trans. Imran Ahsan Khan Nyazee (1st ed., Reading: Garnet Publishing, 2011); Nyazee, *Theories of Islamic Law.*
9. Attia, *Towards Realization*, p.119.
10. Ibid., p.118.
11. Ibid., p.119.
12. Al-Raysuni, *Imam al-Shatibi's Theory.*
13. Al-Shatibi, *The Reconciliation of the Fundamentals of Islamic Law.*
14. Ibid.; and Nyazee, *Theories of Islamic Law.*
15. Omar Qureshi and Aasim I. Padela, "When Must a Patient Seek Healthcare? Bringing the Perspectives of Islamic Jurists and Clinicians into Dialogue," *Zygon* 51(3) (September 2016): 592–625.
16. Attia, *Towards Realization.*
17. Ibid.
18. World Health Organization, "Global Heath Estimates" (2019), accessed December 31, 2022, https://www.who.int/data/global-health-estimates.
19. World Health Organization, "The Top 10 Causes of Death" (2020), accessed December 31, 2022, https://www.who.int/news-room/fact-sheets/detail/the-top-10-causes-of-death.

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21. Aasim I. Padela, and Afshan Mohiuddin, "Islamic Goals for Clinical Treatment at the End of Life: The Concept of Accountability Before God (Taklīf) Remains Useful: Response to Open Peer Commentaries on 'Ethical Obligations and Clinical Goals in End-of-Life Care: Deriving a Quality-of-Life Construct Based on the Islamic Concept of Accountability Before God (Taklīf)'," *American Journal of Bioethics* 15(1) (2015): W1–W8; and Qureshi and Padela, "When Must a Patient Seek Healthcare?"
22. While this hypothetical example draws from the global data which is not necessarily pragmatic for enacting policy, we can imagine policymakers relying on more location-specific data. For example, a state policy actor could look to country-specific data on leading causes of death or to age-specific data and design an agenda to address these.
23. For a good review of the topic, see Prabhat Jha and Richard Peto, "Global Effects of Smoking, of Quitting, and of Taxing Tobacco," *New England Journal of Medicine* 370(1) (2014): 60–68, https://doi.org/10.1056/NEJMra1308383. For some studies on the impact of advertisements on smoking, see James G. Hodge jnr., et al., "Reconsidering the Legality of Cigarette Smoking Advertisements on Television," *Journal of Law, Medicine & Ethics* 41(1) (2013): 369–73, https://doi.org/10.1111/jlme.12026; and Chris Lovato et al., "Impact of Tobacco Advertising and Promotion on Increasing Adolescent Smoking Behaviours," *Cochrane Database of Systematic Reviews* 10 (October 2011). https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD003439.pub2/ful.
24. Connor A. Emdin et al., "Blood Pressure Lowering in Type 2 Diabetes: A Systematic Review and Meta-Analysis," *JAMA* 313(6) (February 10, 2015): 603–15, https://doi.org/10.1001/jama.2014.18574; Kazem Rahimi et al., "The Epidemiology of Blood Pressure and its Worldwide Management," *Circulation Research* 116(6) (March 13, 2015): 925–36, https://doi.org/10.1161/CIRCRESAHA.116.304723; Mattias Brunström and Bo Carlberg, "Effect of Antihypertensive Treatment at Different Blood Pressure Levels in Patients with Diabetes Mellitus: Systematic Review and Meta-Analyses," *BMJ* 352(i717) (2016), https://www.bmj.com/content/352/bmj.i717; Dena Ettehad et al., "Blood Pressure Lowering for Prevention of Cardiovascular Disease and Death: A Systematic Review and Meta-Analysis," *The Lancet* 387(10022) (March 5, 2016): 957–67, https://doi.org/10.1016/S0140-6736(15)01225-8; and Menglin Yue et al., "Meta-Analysis on the Risk of All-Cause Mortality and Cardiovascular Death in the Early Stage of Hypertension," *Pakistan Journal of Pharmaceutical Sciences* 29(4 Suppl.) (July 2016): 1343–51.

25. Norm Campbell et al., "The World Hypertension League and International Society of Hypertension Call on Governments, Nongovernmental Organizations, and the Food Industry to Work to Reduce Dietary Sodium," *The Journal of Clinical Hypertension* 16(2) (2014): 99, https://doi.org/10.1111/jch.12245; and Norm Campbell et al., "PAHO/WHO Regional Expert Group Policy Statement—Preventing Cardiovascular Disease in the Americas by Reducing Dietary Salt Intake Population-Wide," *CVD Prevention and Control* 4(4) (December 2009): 189–91, https://doi.org/10.1016/j.cvdpc.2009.12.003.
26. C.K. Ewart et al., "Effects of School-Based Aerobic Exercise on Blood Pressure in Adolescent Girls at Risk for Hypertension," *American Journal of Public Health* 88(6) (1998): 949–51, https://doi.org/10.2105/ajph.88.6.949.

5. Maqāṣid-Based Models for Clinical Medical Ethics: Moral Deliberation at the Bedside

1. This chapter and Chapter 6 contain slightly modified portions of my article: Aasim I. Padela, "Maqāṣidī Models for an 'Islamic' Medical Ethics: Problem-Solving or Confusing at the Bedside?" *American Journal of Islam and Society* 39(1–2) (2022): 72–114. https://doi.org/10.35632/ajis.v39i1-2.3069.
2. The term bioethics has many different definitions but is a broad field of study that encompasses the ethical, social, and legal issues that arise in the life sciences and biomedicine. Bioethics discourses thus occur within many different settings including the hospital, the home, on public media, and within legislative bodies. As a field, bioethics is expansive and contains several subfields including clinical medical ethics (or medical ethics for short), which focuses on issues arising at the level of the patient, family, and doctor during the course of healthcare decision-making. While Chapter 4 centered on the usefulness and role of the *maqāṣid* in public health policy, this chapter primarily focuses on medical ethics as the realm of application for *maqāṣid*. When referring to the field I use the term bioethics, and when discussing practical ethics deliberation in the clinical realm I use the term medical ethics.
3. Pew Forum on Religion & Public Life, "Mapping the Global Muslim Population: A Report on the Size and Distribution of the World's Muslim Population," dir. Luis Lugo (Washington, DC: Pew Research Center, October 2009), https://www.pewforum.org/2009/10/07/mapping-the-global-muslim-population/.
4. Ibid.
5. See Yacoub Ahmed et al., *The Fiqh of Medicine: Responses in Islamic Jurisprudence to Development in Medical Science* (London: Ta-Ha, 2001); Abdulaziz Abdulhussein Sachedina, *Islamic Biomedical Ethics: Principles and Application* (New York: Oxford University Press, 2009); Mohammed Ali Al-Bar and Hassan Chamsi-Pasha, *Contemporary Bioethics: Islamic Perspective* (Cham: Springer International Publishing, 2015); and Alireza Bagheri and Khalid Abdulla al-Ali (eds.), *Islamic Bioethics: Current*

Issues and Challenges (London: World Scientific Publishing Europe, 2018).

6. For an overview of consumers and producers of Islamic bioethics discourse, see Aasim I. Padela, "An Introduction to Islamic Bioethics: Its Producers and Consumers," in *Medicine and Shariah: A Dialogue in Islamic Bioethics*, ed. Ebrahim Moosa (Notre Dame, IN: University of Notre Dame Press 2021).
7. Morgan Clarke et al., "The Social Politics of Islamic Bioethics," *Die Welt Des Islams* 55(3–4) (November 26, 2015): 265–77, https://doi.org/10.1163/15700607-05534p01; Aasim I. Padela, "Islamic Bioethics: Between Sacred Law, Lived Experiences, and State Authority," *Theoretical Medicine and Bioethics* 34(2) (April 2013): 65–80, https://doi.org/10.1007/s11017-013-9249-1; Mohammed Ghaly, "Islamic Bioethics: The Inevitable Interplay of 'Texts' and 'Contexts': Editorial," *Bioethics* 28(2) (February 2014): ii–v, https://doi.org/10.1111/bioe.12081; Alireza Bagheri, "Islamic Bioethics," *Asian Bioethics Review* 3(4) (2011): 313–15; and Padela, "An Introduction to Islamic Bioethics."
8. Sherine F. Hamdy, "Reframing Islamic Bioethics," *Contending Modernities: A Blog About Catholic, Muslim, and Secular Interaction in the Modern World*, edited by R. Scott Appleby, (September 18, 2013), https://contendingmodernities.nd.edu/field-notes/reframing-islamic-bioethics/; Abdulaziz Sachedina, "Is There an Islamic Bioethics?" *Contending Modernities* (March 12, 2013), accessed December 23, 2022, https://contendingmodernities.nd.edu/field-notes/is-there-an-islamic-bioethics/; and Mohammed Ali Shomali, "Islamic Bioethics: A General Scheme," *Journal of Medical Ethics and History of Medicine* 1(1) (October 19, 2008).
9. Abdulaziz Sachedina, "Defining the Pedagogical Parameters of Islamic Bioethics," in *Muslim Medical Ethics: From Theory to Practice*, ed. Jonathan E. Brockopp and Thomas Eich (Columbia, SC: University of South Carolina Press, 2008), pp.241–251.
10. Sachedina, *Islamic Biomedical Ethics*; Omar Qureshi and Aasim I. Padela "When Must a Patient Seek Healthcare? Bringing the Perspectives of Islamic Jurists and Clinicians into Dialogue," *Zygon* 51(3) (September 2016): 592–625; and Hassan Chamsi-Pasha and Mohammed Ali Albar, "Western and Islamic Bioethics: How Close is the Gap?" *Avicenna Journal of Medicine* 3(1) (January–March 2013): 8–14, https://doi.org/10.4103/2231-0770.112788.
11. Aasim I. Padela et al., "Medical Experts & Islamic Scholars Deliberating over Brain Death: Gaps in the Applied Islamic Bioethics Discourse," *The Muslim World* 101(1) (2011): 53–72, https://doi.org/10.1111/j.1478-1913.2010.01342; Aasim I. Padela et al., "Brain Death in Islamic Ethico-Legal Deliberation: Challenges for Applied Islamic Bioethics," *Bioethics* 27(3) (March 2013): 132–39, https://doi.org/10.1111/j.1467-8519.2011.01935; and Aasim I. Padela, "Public Health Measures & Individualized Decision-Making: The Confluence of the H1NVaccine and Islamic Bioethics," *Human Vaccines* 6(9) (September 12, 2010): 12–15, https://doi.org/10.4161/hv.6.9.12015.

12. Omar Hasan Kasule, "Biomedical Ethics: An Islamic Formulation," *Journal of the Islamic Medical Association of North America* 42(1) (April 9, 2010).
13. Gamal Eldin Attia, *Towards Realization of the Higher Intents of Islamic Law: Maqāṣid al-Shariʿah, A Functional Approach* (Herndon, VA: IIIT, 2007); and Jasser Auda, *Maqāṣid al-Sharīʿah: A Beginner's Guide* (London: IIIT, 2008).
14. Mohammad Hashim Kamali, *Maqāṣid al-Sharīʿah, Ijtihad and Civilisational Renewal*, (London: IIIT, 2012), p.20; and Jasser Auda, *Maqasid al-Shariah as Philosophy of Islamic Law: A Systems Approach* (London: IIIT, 2008).
15. Abul Fadl Mohsin Ebrahim, "Vaccination in the Context of *Al-Maqasid Al-Shariʿah*: Objectives of Divine Law and Islamic Medical Jurisprudence," *Arabian Journal of Business and Management Review (Oman Chapter)* 3(9) (May 2014): 44–52, https://doi.org/10.12816/0016499; Shaikh Mohd Saifuddeen et al., "Maqasid Al-Shariah as a Complementary Framework to Conventional Bioethics," *Science and Engineering Ethics* 20(2) (June 2014): 317–27, https://doi.org/10.1007/s11948-013-9457-0; Omar Hasan Kasule, "Analysis of the Medical Decisions of the International Fiqh Academy from the Perspectives of the *Maqasid Al Shariʿat* and *Qawaʿid Al Fiqh*," *Integrated Medical Education Resources* (blog), 2015, https://omarkasule-tib.blogspot.com/2015/06/150309p-analysis-of-medical-decisions.html; Omar Hasan Kasule, "Understanding Basic Principles of Maqasid Al Shariʿat for Healthcare Workers," *Integrated Medical Education Resources* (blog), 2009, https://omarkasule-tib.blogspot.com/2011/07/091018p-understanding-basic-principles.html; Omar Hasan Kasule, "Islamic Medical Ethics with Special Reference to Maqasid al Shariʿat," 2007, http://ihcmalaysia.my/index.php/list-of-publications/38-maqasid-syariah; Omar Hasan Kasule, "The Application of Maqasid Al Shariʿat in Medical Practice," *Integrated Medical Education Resources* (blog), 2006, https://omarkasule-tib.blogspot.com/2011/05/0609p-application-of-maqasid-al-shariat.html; Bouhedda Ghalia et al., "Medical Ethics in the Light of *Maqāṣid Al-Sharīʿah*: A Case Study of Medical Confidentiality," *Intellectual Discourse* 26(1) (June 12, 2018): 133–60; Abdul Halim Ibrahim et al., "Tri-Parent Baby Technology and Preservation of Lineage: An Analysis from the Perspective of *Maqasid al-Shariʿah* Based Islamic Bioethics," *Science and Engineering Ethics* 25(1) (February 2019): 129–42, https://doi.org/10.1007/s11948-017-9980-5; and Abdul Halim Ibrahim et al., "Maqasid Al-Shariah as a Complementary Framework for Conventional Bioethics: Application in Malaysian Assisted Reproductive Technology (ART) Fatwa," *Science and Engineering Ethics* 24(5) (October 2018): 1493–502, https://doi.org/10.1007/s11948-017-9963-6.
16. I am aware of such teaching occurring in medical schools throughout Malaysia and more recently in Saudi Arabia.
17. Discussed in detail in Chapter 2.

18. Although there is reference to the *maqāṣid* in many medically oriented fatwas, it is most often referred to in order to buttress fiqh-based ethical determinations. Moreover, given the genre, such writings are short and do not provide details on the deliberative frameworks using *maqāṣid*. As such, I restricted my sources of study to the extant Islamic bioethics literature in English, which provides the space for greater elaboration and represent attempts by Muslim scholars to engage contemporary medical ethics stakeholders. Additionally, English is the language used by authors seeking to engage with interlocutors in academic bioethics given that it is the language of the discourse, hence my restriction is appropriate. Nonetheless the reasoning exercises of contemporary jurists with respect to clinical medical ethics and the use of *maqāṣid* therein merits further study.
19. See Chapter 2.
20. At the same time, since the focus of my study is on scholarly writings that address medical ethics from a *maqāṣid* perspective, the sources I use may not represent each theoretical model fully. A fuller study is needed to comprehensively review how scholars have built upon al-Shatibi's work to furnish newer models of the *maqāṣid al-Sharīᶜah*.
21. Kasule, "Biomedical Ethics," p.39.
22. Ibid.
23. Siti Hafsyah Idris et al., "Beyond *Halal*: *Maqasid al-Shariᶜah* to Assess Bioethical Issues Arising from Genetically Modified Crops," *Science and Engineering Ethics* 26(3) (2020): 1463–76, https://doi.org/10.1007/s11948-020-00177-6.
24. Kasule, "The Application of Maqasid Al Shariᶜat in Medical Practice."
25. Ibid.
26. Ibid.
27. Ibid.
28. Ibid.
29. Ibid.; Kasule, "Biomedical Ethics"; and Saifuddeen et al., "Maqasid Al-Shariah as a Complementary Framework."
30. Saifuddeen et al., "Maqasid Al-Shariah as a Complementary Framework," p.324.
31. Kasule, "Biomedical Ethics."
32. Abdul Halim Ibrahim et al., "Maqasid Al-Shariah Based Islamic Bioethics: A Comprehensive Approach," *Journal of Bioethical Inquiry* 16(3) (September 2019): 338, https://doi.org/10.1007/s11673-019-09902-8.
33. Saifuddeen et al., "Maqasid Al-Shariah as a Complementary Framework."
34. Ibrahim et al., "Maqasid Al-Shariah Based Islamic Bioethics."
35. Ibid., p.6.
36. Ibid., p.10.
37. Saifuddeen et al., "Maqasid Al-Shariah as a Complementary Framework"; and Ibrahim et al., "Maqasid Al-Shariah as a Complementary Framework for Conventional Bioethics."

38. Ebrahim, "Vaccination in the Context of *Al-Maqasid Al-Shariᶜah*."
39. Ghalia et al., "Medical Ethics in the Light of *Maqāṣid Al-Sharīᶜah*."
40. Musa Mohd Nordin, "Immunisation from the Perspective of Maqasid Shariᶜah," *Bangladesh Journal of Medical Science* 15(2) (August 10, 2016): 151–53; Sharmin Islam, "Shariᶜah Guidelines for Biomedical Jurisprudence and Medical Ethics from Maqasid al-Sharᶜiah," *Encyclopedia of Islamic Medical Ethics: Part VII Maqasid al-Shariᶜah and Medical Jurisprudence and Bioethics* (Amman: Jordan Society for Islamic Medical Sciences, February 2022); Muhammad Aa'zamuddin Ahmad Radzi et al., "An Overview of the Application of Maqasid Al-Shariah into Cartilage Tissue Engineering," *IIUM Medical Journal Malaysia* 17(1) (July 18, 2018); Mehrunisha Suleman and Aziz Sheikh, "Islam and COVID-19: Understanding the Ethics of Decision Making during a Pandemic," *Journal of Global Health* (11) (2021): 1–4, https://jogh.org/islam-and-covid-19-understanding-the-ethics-of-decision-making-during-a-pandemic/; and Faizatul Najihah Azaman et al., "Palliative Care and Hospice Care from the Perspective of the Maqasid Sharīᶜah," *Al-Risalah: Journal of Islamic Revealed Knowledge and Human Sciences (ARJIHS)* 5(2) (2021): 167–85, https://doi.org/10.31436/alrisalah.v5i2.319.
41. Kasule, "Analysis of the Medical Decisions of the International Fiqh Academy," p.3.
42. Saifuddeen et al., "Maqasid Al-Shariah as a Complementary Framework"; and Omar Hasan Kasule, "Preservation of Progeny: A Medical Perspective[1] (*maqsad hifdh al nasl: al mandhuur al tibbi*)," *Integrated Medical Education Resources*, April 2011, https://omarkasule-tib.blogspot.com/2011/04/070708p-preservation-of-progeny-medical.html.
43. Kasule, "Islamic Medical Ethics with Special Reference to Maqasid al Shariᶜat."
44. Saifuddeen et al., "Maqasid Al-Shariah as a Complementary Framework." For greater details on the four principle approach, see Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 8th ed. (New York: Oxford University Press, 2019).
45. Ebrahim, "Vaccination in the Context of *Al-Maqasid Al-Shariᶜah*."
46. Ghaiath Hussein, "What Can Ethics Learn from Islamic Legislation?: An Islamic Approach to Moral Analysis Based on the Purposes of Islamic Legislation (Maqasid Al-Shariyaᶜa)," paper presented at the Second International Bioethics Conference, Sultan Qaboos University, Oman, February 2020.
47. Attia, *Towards Realization*.
48. Auda, *Maqasid Al-Shariah as Philosophy of Islamic Law*; Tariq Ramadan, *Radical Reform: Islamic Ethics and Liberation* (Oxford: Oxford University Press, 2009); Attia, *Towards Realization*; Yusuf al-Qaradawi, "Medicine Containing Alcohol for Preservation Purposes," *Halal Industry Development Corporation*, accessed 2020; and Yusuf al-Qaradawi, *The Lawful and the Prohibited in Islam* (Kuala Lumpur: Islamic Book Trust, 2013).

49. Attia, *Towards Realization*, p.195.
50. Attia, *Towards Realization*.
51. Ibid.
52. Ibid., p.11.
53. Ibid., p.119.
54. Ibid.
55. Ibid., p.122.
56. Ibid., p.32.
57. Ibid.
58. Ramadan, *Radical Reform*, p.142.
59. Ibid., p.136.
60. Ibid.
61. Ibid., p.138.
62. Ibid., p.136.
63. Ibid., p.139.
64. Tariq Ramadan, "The Challenges and Future of Applied Islamic Ethics Discourse: A Radical Reform?," *Theoretical Medicine and Bioethics* 34(2) (April 2013): 105–15, https://doi.org/10.1007/s11017-013-9246-4.
65. Ramadan, *Radical Reform*, p.159.
66. Ibid., p.176.
67. Deuraseh Nurdeng, "New Essential Values of daruriyyah (Necessities) of the Objectives of Islamic Law (maqasid al-Shariᶜah)," *Islamic Philosophy and Civilization* 4(2) (2012): 112.
68. Azizan Baharuddin et al., "A Preliminary Insight into an Islamic Mechanism for Neuroethics," *The Malaysian Journal of Medical Sciences* 23(1) (2016): 1.
69. It is critically important to recognize that al-Shāṭibī's theory is based on induction from scripture. Hence, the text-based postulation approach is also, albeit tenuously, linked to scripture.
70. Ahmad al-Raysuni, *Imam al-Shatibi's Theory of the Higher Objectives and Intents of Islamic Law*, trans. Nancy Roberts (London: IIIT, 2005).
71. Imran Ahsan Khan Nyazee, *Theories of Islamic Law* (Islamabad: Islamic Research Institute, 2002).
72. Aasim I. Padela, "The Essential Dimensions of Health According to the Maqasid Al-Shariᶜah Frameworks of Abu Ishaq al-Shatibi and Jamal-al-Din-ᶜAtiyah," *IIUM Medical Journal Malaysia* 17(1) (July 18, 2018): 49–58, https://doi.org/10.31436/imjm.v17i1.1035.
73. Kamali, *Maqāṣid al-Sharīᶜah, Ijtihad and Civilisational Renewal*; and Padela, "The Essential Dimensions of Health."

6. The Crucible of a "Brain-Dead" Pregnant Woman: Do Maqāṣid Frameworks for Medical Ethics Meet the Challenge?

1. As noted in Chapter 5, this chapter is a slightly modified portion of my article: Aasim I. Padela, "Maqāṣidī Models for an 'Islamic' Medical Ethics: Problem-Solving or Confusing at the Bedside?," *American Journal of Islam and Society* 39(1–2) (2022): 72–114, https://doi.org/10.35632/ajis.v39i1-2.3069.
2. I have placed the term brain death in quotations to highlight that the term is a misnomer and controversial. "Brain death" is often used to denote that neurologic criteria for human death have been met. Though the phrase uses the term "death," this death is actually referring to the death of the human being and not of the brain, because when neurologic criteria for death are met the entirety of the brain may not have ceased functioning. Moreover, the term controversially fuses medical fact with an attributed value. The medical fact that an individual who has met the neurological criteria for death will not be able to be revived to consciousness based on contemporary medical knowledge and biotechnology is fused with the value that such a state represents a life not worth living and/or maintaining. Both the medical fact here and the value attributed to it are contentious. Throughout the rest of the paper quotation marks will not be used for the sake of maintaining flow, but the reader should hold these controversies in mind.
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4. Seema K. Shah and Franklin Miller, "Can We Handle the Truth? Legal Fictions in the Determination of Death," *American Journal of Law & Medicine* 36(4) (2010): 540–85, https://doi.org/10.1177/009885881003600402; John P. Lizza, *Persons, Humanity, and the Definition of Death* (Baltimore, MD: Johns Hopkins University Press, 2006); and John P. Lizza, "Defining Death for Persons and Human Organisms," *Theoretical Medicine and Bioethics* 20(5) (1999): 439–53, https://doi.org/10.1023/a:1009946723857.
5. Aasim I. Padela et al., "Brain Death in Islamic Ethico-Legal Deliberation: Challenges for Applied Islamic Bioethics," *Bioethics* 27(3) (March 2013): 132–39, https://doi.org/10.1111/j.1467-8519.2011.01935; Aasim I. Padela et al., "Medical Experts & Islamic Scholars Deliberating over Brain Death: Gaps in the Applied

Islamic Bioethics Discourse," *The Muslim World* 101(1) (2011): 53–72, https://doi.org/10.1111/j.1478-1913.2010.01342; Johannes Grundmann, "Shariʿah, Brain Death, and Organ Transplantation: The Context and Effect of Two Islamic Legal Decisions in the Near and Middle East," *American Journal of Islam and Society* 22(4) (2005): 1–25, https://doi.org/10.35632/ajis.v22i4.459; Birgit Krawietz, "Brain Death and Islamic Traditions: Shifting Borders of Life?" in *Islamic Ethics of Life: Abortion, War, and Euthanasia*, ed. Jonathan E. Brockopp (Columbia, SC: University of South Carolina Press, 2003), pp.194–213; and Andrew C. Miller et al., "Brain Death and Islam: The Interface of Religion, Culture, History, Law, and Modern Medicine," *Chest* 146(4) (October 2014): 1092–110.

6. Majid Esmaeilzadeh et al., "One Life Ends, Another Begins: Management of a Brain-Dead Pregnant Mother—A Systematic Review," *BMC Medicine* 8(74) (2010), https://doi.org/10.1186/1741-7015-8-74; and Abuhasna Said et al., "A Brain-Dead Pregnant Woman with Prolonged Somatic Support and Successful Neonatal Outcome: A Grand Rounds Case with a Detailed Review of Literature and Ethical Considerations," *International Journal of Critical Illness and Injury Science* 3(3) (2013): 220–24. .
7. American College of Obstetricians and Gynecologists, "Periviable Birth," *Obstetric Care Consensus* 130(4) (2017).
8. Fetal age differs from gestational age. Gestational age is the length of pregnancy calculated from the first day of the last menstrual period. On the other hand, fetal age corresponds to the posited age of the fetus based on conception. Fetal age is about two weeks less than gestational age. See Abdulaziz Sachedina, *Islamic Biomedical Ethics: Principles and Application*. New York: Oxford University Press, 2009; and Alireza Bagheri (ed.), *Abortion: Global Positions and Practices, Religious and Legal Perspectives* (Cham: Springer International, 2021).
9. Hamza Yusuf, "When Does a Human Foetus become Human?" in *Islam and Biomedicine*, ed. Afifi al-Akiti and Aasim I. Padela (Cham: Springer, 2022), pp.113–34; and Muhammad ibn Adam Al-Kawthari, *Birth Control & Abortion in Islam* (Santa Barbara, CA: White Thread Press, 2006).
10. See Abul Fadl Mohsin Ebrahim, *An Introduction to Islamic Medical Jurisprudence* (Durban: Islamic Medical Association of South Africa, 2008), pp.111–16.
11. I recognize that my phraseology may appear provocative. However, I am trying to nuance the fact that some brain functions may persist in an individual declared to be brain-dead and that future technology may herald a new-found capacity to restore consciousness in some individuals declared brain-dead. In other words, my phrasing here suggests that brain death is more a prognostic entity than a diagnostic one.
12. On the other hand, if the state was considered to be a dead one, the preservation of life does not apply for the mother. The lower-order principles would have to be examined. However, sustaining the mother advantages the preservation of life of the

fetus, hence, one can argue that the preservation of life remains applicable, even if the mother is considered to be a dead person.

13. The previous note applies here as well.
14. An Islamic legal maxim reads the living take precedence over the dead.
15. Robert D. Truog, "Brain Death—Too Flawed to Endure, Too Ingrained to Abandon," *Journal of Law, Medicine & Ethics* 35(2) (2007): 273–81, https://doi.org/10.1111/j.1748-720X.2007.00136.x; Robert D. Truog, "Is It Time to Abandon Brain Death?" *Hastings Center Report* 27(1) (1997): 29–37. https://doi.org/10.1002/j.1552-146X.1997.tb00021.x; D. Alan Shewmon, "Brainstem Death, Brain Death and Death: A Critical Re-Evaluation of the Purported Equivalence," *Issues in Law & Medicine* 14(2) (1998): 125–45; Ari R. Joffe, "Brain Death Is Not Death: A Critique of the Concept, Criterion, and Tests of Brain Death," *Reviews in the Neurosciences* 20(3–4) (January 2009), https://doi.org/10.1515/REVNEURO.2009.20.3-4.187; Amir Halevy and Baruch Brody, "Brain Death: Reconciling Definitions, Criteria, and Tests," *Annals of Internal Medicine* 119(6) (September 15, 1993): 519–25, https://doi.org/10.7326/0003-4819-119-6-199309150-00013; Christopher James Doig and Ellen Burgess, "Brain Death: Resolving Inconsistencies in the Ethical Declaration of Death," *Canadian Journal of Anesthesia/Journal Canadien d'anesthésie* 50(7) (August 2003): 725–31, https://doi.org/10.1007/BF03018718; Veatch and Friedman Ross, *Defining Death*; and Aasim I. Padela, "Muslim Disquiet over Brain Death: Advancing Islamic Bioethics Discourses by Treating Death as a Social Construct that Aligns Purposes with Criteria and Ethical Behaviors," in *End-of-Life Care, Dying and Death in the Islamic Moral Tradition*, ed. Mohammed Ghaly (Leiden: Brill, 2022), pp.50–80.
16. Ramadan's writings do not make clear whether this is a single objective with two components or two objectives. For ease of analysis, I have separated the objective into two separate objectives in this chapter.
17. Ayman Shihadeh, "Introduction: The Ontology of the Soul in Medieval Arabic Thought," *The Muslim World* 102(3–4) (October 2012): 413–16, https://doi.org/10.1111/j.1478-1913.2012.01405.x; Jihad Hashim Brown, *The Problem of Reductionism in Philosophy of Mind and Its Implications for Theism and the Principle of Soul: Framing the Issue for Further Islamic Inquiry* (Abu Dhabi: Tabah Foundation, 2013); Faisal Qazi et al., "Framing the Mind–Body Problem in Contemporary Neuroscientific and Sunni Islamic Theological Discourse," *The New Bioethics* 24(2) (2018): 158–75, https://doi.org/10.1080/20502877.2018.1438835; Timothy J. Gianotti, *Al-Ghazali's Unspeakable Doctrine of the Soul: Unveiling the Esoteric Psychology and Eschatology of the Ihya* (Leiden: Brill, 2001); Omar Sultan Haque, "Brain Death and Its Entanglements: A Redefinition of Personhood for Islamic Ethics," *Journal of Religious Ethics* 36(1) (March 2008): 13–36,

https://doi.org/10.1111/j.1467-9795.2008.00334.x; Ebrahim Moosa, "Languages of Change in Islamic Law: Redefining Death in Modernity," *Islamic Studies* 38(3) (1999): 305–42; and Ahmet Bedir and Şahin Aksoy, "Brain Death Revisited: It Is Not 'Complete Death' According to Islamic Sources," *Journal of Medical Ethics* 37(5) (May 1, 2011): 290–94.

18. Muhammad ibn Adam al-Kawthari, *Birth Control & Abortion in Islam* (London: White Thread Press, 2006); Farhat Moazam, "Islamic Perspectives on Abortion," *Bioethics Links* 1(2) (August 2005): 3–4; Marion Holmes Katz, "The Problem of Abortion in Classical Sunni Fiqh," in *Islamic Ethics of Life: Abortion, War, and Euthanasia*, ed. Jonathan E. Brockopp (Columbia, SC: University of South Carolina Press, 2003), pp.25–50; Thomas Eich, "Induced Miscarriage in Early Mālikī and Hanafī Fiqh," *Islamic Law and Society* 16(3–4) (2009): 302–36, https://doi.org/10.1163/092893809X12469547140991; Muhammed V. Stodolsky and Aasim I. Padela, "Abortion in Hanafi Law," in *Abortion: Global Positions and Practices, Religious and Legal Perspectives*, ed. Alireza Bagheri (Cham: Springer, 2021), pp.127–36; and Mohammed Ghaly, "The Beginning of Human Life: Islamic Bioethical Perspectives," *Zygon*47(1) (March 2012): 175–213.

19. Shihadeh, "Introduction"; Brown, *The Problem of Reductionism*; Qazi et al., "Framing the Mind–Body Problem"; Gianotti, *Al-Ghazali's Unspeakable Doctrine of the Soul*; Haque, "Brain Death and Its Entanglements"; Moosa, "Languages of Change in Islamic Law"; and Bedir and Aksoy, "Brain Death Revisited."

20. Moosa, "Languages of Change in Islamic Law"; and Padela et al., "Brain Death in Islamic Ethico-Legal Deliberation."

21. Margaret Lock, "On Dying Twice: Culture, Technology and the Determination of Death," in *Living and Working with the New Medical Technologies: Intersections of Inquiry*, ed. Margaret Lock, Allan Young, and Alberto Cambrosio (Cambridge: Cambridge University Press, 2000), p.233.

22. Konstantinos G. Karakatsanis, "'Brain Death': A Utilitarian Construct, Not Biological Death-The Reasons the Concept of 'Brain Death' Should Be Abandoned," *International Journal of Studies in Nursing* 4(1) (2019): 30, https://doi.org/10.20849/ijsn.v4i1.544.

23. J. Parker, "Criteria of Life: Some Methods of Measuring Viability," *American Scientist*, 41(4) (1953): 614–18.

24. Aasim I. Padela, "Social Responsibility and the State's Duty to Provide Healthcare: An Islamic Ethico-Legal Perspective," *Developing World Bioethics* 17(3) (December 2017): 205–14, https://doi.org/10.1111/dewb.12140; and Aasim I. Padela, "The Essential Dimensions of Health According to the Maqasid Al-Shariᶜah Frameworks of Abu Ishaq al-Shatibi and Jamal-al-Din-ᶜAtiyah," *IMJM* 17(1) (2018): 49–58, https://doi.org/10.31436/imjm.v17i1.1035.

25. Abrar Khan, "Brain Death Legislation and Organ Transplantation in the Islamic World," *Middle East Health Magazine* (September 2009), http://www.middleeasthealthmag.com/; and Miller et al., "Brain Death and Islam."
26. Blair Wendlandt et al., "Modifiable Elements of ICU Supportive Care and Communication Are Associated with Surrogates' PTSD Symptoms," *Intensive Care Medicine* 45(5) (2019): 619–26, https://doi.org/10.1007/s00134-019-05550-z; Jesse J. Miller et al., "Decision Conflict and Regret among Surrogate Decision Makers in the Medical Intensive Care Unit," *Journal of Critical Care* 32 (April 2016): 79–84, https://doi.org/10.1016/j.jcrc.2015.11.023; Cynthia J. Gries et al., "Family Member Satisfaction With End-of-Life Decision Making in the ICU," *Chest* 133(3) (March 2008): 704–12, https://doi.org/10.1378/chest.07-1773; and Blair Wendlandt et al., "Risk Factors for Post-Traumatic Stress Disorder Symptoms in Surrogate Decision-Makers of Patients with Chronic Critical Illness," *Annals of the American Thoracic Society* 15(12) (December 2018): 1451–58, https://doi.org/10.1513/AnnalsATS.201806-420OC.
27. Grundmann, "Shariʿah, Brain Death, and Organ Transplantation"; Aasim I. Padela, "The Perspectives of Islamic Jurists on the Brain Death as Legal Death in Islam," *Journal of Religion and Health* 55 (August 2016): 1215–17; Abdulaziz Sachedina, "Brain Death in Islamic Jurisprudence," *Ijtihad Network*, March 23, 2022, http://ijtihadnet.com/brain-death-islamic-jurisprudence-abdulaziz-sachedina/; and Krawietz, "Brain Death and Islamic Traditions."
28. Padela, "The Perspectives of Islamic Jurists on the Brain Death as Legal Death in Islam"; Mohammed Ali al-Bar and Hassan Chamsi-Pasha, *Contemporary Bioethics: Islamic Perspective* (Cham: Springer International Publishing, 2015); and Dariusch Atighetchi, *Islamic Bioethics: Problems and Perspectives* (New York: Springer, 2009).
29. Padela et al., "Brain Death in Islamic Ethico-Legal Deliberation."
30. One could argue that since the rulings I quote are about non-pregnant patients they are not applicable. Rather, fresh rulings are needed for this scenario. While that might be true, I am trying to show that there is potential dissonance between established fiqh and the *maqāṣid*-based medical ethics approaches presented. Proponents may argue that the role of *maqāṣid*-based analysis is to motivate new rulings, and that the dissonance is a positive feature of these medical ethics models. This reasoning does have some merit.
31. Omar Qureshi and Aasim I. Padela, "When Must a Patient Seek Healthcare? Bringing the Perspectives of Islamic Jurists and Clinicians into Dialogue." *Zygon* 51(3) (September 2016): 592–625; and Mohammed Ali Albar, "Seeking Remedy, Abstaining from Therapy and Resuscitation: An Islamic Perspective," *Saudi Journal of Kidney Diseases and Transplantation* 18(4) (2007): 629–37.
32. Aasim I. Padela and Omar Qureshi, "Islamic Perspectives on Clinical Intervention Near the End-of-Life: We Can but Must We?" *Medicine, Health Care, and Philosophy* 20(4) (December 2017): 545–59, https://doi.org/10.1007/s11019-016-9729-y.

33. Gamal Eldin Attia, *Towards Realization of the Higher Intents of Islamic Law: Maqāṣid al-Shariʿah, A Functional Approach* (Herndon, VA: IIIT, 2007).
34. In the Islamic tradition, the human body is accorded the rights of inviolability, even after human death. This is based on many different scriptural texts including the famous narration that breaking the bone of a dead individual is akin to breaking the bone of a living individual. See Abu Dawud, *Sunan Abu Dawud* 3207.
35. Jonathan E. Brockopp, *Islamic Ethics of Life: Abortion, War, and Euthanasia* (Columbia, SC: University of South Carolina Press, 2003); and Al-Bar and Chamsi-Pasha, *Contemporary Bioethics*.
36. Daniel Beck, "Between Relativism and Imperialism: Navigating Moral Diversity in Cross-Cultural Bioethics," *Developing World Bioethics* 15(3) (December 2015): 162–71, https://doi.org/10.1111/dewb.12059.
37. Recall that Islamic bioethics is broader in scope than medical fiqh and clinical medical ethics.
38. By and large this remains the case as Muslim stakeholders seek the advice of Islamic jurists when faced with an ethical dilemma during the course of clinical care or biomedical research.
39. Mohammed Ghaly, "Biomedical Scientists as Co-Muftis: Their Contribution to Contemporary Islamic Bioethics," *Die Welt des Islams* 55(3–4) (2015): 286–311, https://doi.org/10.1163/15700607- 05534p03; and Muhammed V. Stodolsky and M.A. Kholwadia, "A Jurisprudential (Uṣūlī) Framework for Cooperation between Muslim Jurists and Physicians and its Application to the Determination of Death," in *Medicine and Shariah: A Dialogue in Islamic Bioethics*, ed. Aasim I. Padela (Notre Dame, IN: University of Notre Dame Press, 2021), pp.71–86.
40. Aasim I. Padela, "Complexities of Biomedicine, Theology and Politics in Islamic Bioethical Deliberation over Female Genital Procedures: A Reply to 'The Prosecution of Dawoodi Bohra Women' by Richard Shweder," *Global Discourse* 12(1) (2022): 115–29, https://doi.org/10.1332/204378921X16334660756430; Aasim I. Padela (ed.), *Medicine and Shariah: A Dialogue in Islamic Bioethics* (Notre Dame, IN: University of Notre Dame Press, 2021); Aasim I. Padela et al., "Aligning Medical and Muslim Morality: An Islamic Bioethical Approach to Applying and Rationing Life Sustaining Ventilators in the COVID-19 Pandemic Era," *Journal of Islamic Ethics* 7(1–2) (2023): 129–64, https://doi.org/10.1163/24685542-12340061; and Aasim I. Padela, "Islamic Bioethics: Between Sacred Law, Lived Experiences, and State Authority," *Theoretical Medicine and Bioethics* 34(2) (2013): 65–80, https://doi.org/10.1007/s11017-013-9249-1.
41. An Islamic ethico-legal maxim reads *al-ḥukm ʿala shay farʾ ʿan taṣawwurihi* ("The ethico-legal assessment of a matter depends on its conceptualization").
42. The reader is directed to the chapter "Jurists, Physicians, and Other Experts in Dialogue: A Multidisciplinary Vision for Islamic Bioethical Deliberation," in

Medicine and Shariah: A Dialogue in Islamic Bioethics (Notre Dame, IN: University of Notre Dame Press, 2021), pp.227–34, where I lay out the conceptual and process model for an enhanced Islamic bioethics-focused collective ijtihad.

434. I demonstrate such analyses in relationship to the question of ventilator application and rationing in Padela et al., "Aligning Medical and Muslim Morality."

7. Preserving Life or Preserving Religion? The Highest Objective in Healthcare

1. In al-Shatibi's *al-Muwafaqqāt fi uṣūl al-Sharīᶜah*, he discusses four dimensions to God's purposes: The first dimension relates to securing human interests through law; the second relates to making the law knowable and comprehensible; the third dimension concerns making some actions obligatory to perform; and the forth relates to the rationale for making humankind follow Islamic law. Throughout this book, I have discussed aspects of this first dimension as it is most relevant to discussing how the human interests and the obligation to preserve them can be actualized in biomedicine. However, the other dimensions must be acknowledged when fully aligning biomedicine with *Sharīᶜah*.
2. As noted in previous chapters, some theorists would say that some purposes can also be gleaned by reason reflecting upon the natural world.
3. Ibrāhīm ibn Mūsā Abū Isḥāq al-Shatibi, *The Reconciliation of the Fundamentals of Islamic Law, Vol. 2: Al-Muwāfaqāt fī Usūl al-Sharīᶜa*, trans. Imran Ahsan Khan Nyazee (1st ed., Reading: Garnet Publishing, 2011), p.3.
4. Ibid., p.135.
5. In Plato's *Euthyphro*, Socrates encounters the priest Euthyphro in front of the courthouse in Athens and they engage in a discussion on the nature or definition of piety or 'holiness' where Socrates famously asks Euthyphro whether the Gods love something because it is (inherently already) holy or is something holy because the Gods love it.
6. My review of these positions leaves many details untouched. The conceptual boundaries between the three camps have been somewhat fluid as classical jurists switched from one camp to another and accomplished theologians advanced their own nuanced amendments to standard views. The reader is directed to the following texts for a greater exposition of the standard views: Jasser Auda, *Maqasid al-shariah as Philosophy of Islamic Law: A Systems Approach* (Washington, DC: IIIT, 2008); Sherman A. Jackson, *Islam and the Problem of Black Suffering* (Oxford: Oxford University Press, 2009); and Anver M. Emon, *Islamic Natural Law Theories* (Oxford: Oxford University Press, 2010).
7. The Sunni schools place different sorts of constraints on the use of independent reason to generate Islamic law. The Maliki school stands out from the others in giving the widest scope to reason as encapsulated by the construct of *maṣlaḥah*

mursalah. The Shiᶜi schools of law also give wide berth to human reason as they consider human reason to be an independent source of legislation.

8. Ali al-Qaradaghi, "Formulating Ethical Principles in Light of the Higher Objectives of Sharia and Their Criteria," in *Islamic Perspectives on the Principles of Biomedical Ethics: Muslim Religious Scholars and Biomedical Scientists in Face-to-Face Dialogue with Western Bioethicists*, ed. Mohammed Ghaly (London: World Scientific Publishing/Imperial College Press, 2018), pp.317–39.
9. Gamal Eldin Attia, *Towards Realization of the Higher Intents of Islamic Law: Maqāṣid al-Shariᶜah, A Functional Approach* (Herndon, VA: IIIT, 2007).
10. Throughout this book I have translated *ḥifẓ al-dīn* as the preservation of religion. Yet, as this discussion illustrates, classical theorists did not actually mean religion by the term. Rather, they meant the preservation of Islam. In other words, by the preservation of religion, they meant the maintenance of religious practices and identity for Muslim subjects, and the existence of Islam as a global religious tradition for non-Muslims because that would allow for the possibility non-Muslims could secure their hereafter by becoming Muslims. Some contemporary scholars, on the other hand, extend the notion to represent freedom of religion and even the freedom to not have a religion.
11. Adi Setia, "Freeing *Maqāṣid* and *Maṣlaḥa* from Surreptitious Utilitarianism, *Islamic Sciences* 14(2) (2016): 134.
12. Ibid., p.135.
13. Attia, *Towards Realization*, p.25.
14. Imam Yahya ibn Sharaf al-Nawawi, *Riyad-as-Saliheen: The Book of Miscellany*, p.584.
15. Ibid., p.585.
16. Cf. (2:173, 5:3).
17. Attia, *Towards Realization*, p.24.
18. I am referring to the *ḥuqūq Allah* and *ḥuqūq al-ᶜibād* heuristic here. The English term 'rights' does not precisely capture the nuance of the more expansive notion of *ḥuqūq* in Islam, and there are many conceptual problems that result from overlaying modern notions of rights onto *ḥuqūq* in Islamic ethico-legal theory. See Anver M. Emon, "Huqūq Allāh and Huqūq al-ᶜIbād: A Legal Heuristic for a Natural Rights Regime," *Islamic Law and Society* 13(3) (2006): 325–91, https://doi.org/10.1163/156851906778946350; Ebrahim Moosa, "The Dilemma of Islamic Rights Schemes," *Journal of Law and Religion* 15 (2001): 185–215, https://doi.org/10.2307/1051518; and Aasim I. Padela, "Rooting the Universals of Bioethics and Human Rights in Natural Law: An Islamic Response to 'The Christian-Catholic Religious Perspective: Human Rights, Cultural Pluralism, and Bioethics' by Professor Laura Palazanni," *Religious Perspectives on Bioethics and Human Rights*, ed. Joseph Tham et al. (Cham: Springer, 2017), pp.217–28.
19. Attia, *Towards Realization*, p.22.

20. Attia, *Towards Realization*, pp.25–26.
21. There is no shortage of topics that stir controversy about how religious values inform healthcare delivery. The recent public, professional, and policy conversations around abortion provision in the United States in light of the *Dobbs* vs. *Jackson* ruling (October 2021) is but one example. Other recent debates surround religious exemptions from COVID-19 vaccination and physician aid-in-dying.
22. Wendy Cadge and Emily Sigalow, "Negotiating Religious Differences: The Strategies of Interfaith Chaplains in Healthcare," *Journal for the Scientific Study of Religion* 52(1) (March 2013): 146–158, https://doi.org/10.1111/jssr.12008; and Lisa Stevenson, "Praying Along: Interfaith Chaplaincy and the Politics of Translation," in *Shattering Culture: American Medicine Responds to Cultural Diversity*, ed. Mary-Jo DelVecchio Good et al. (New York: Russell Sage Foundation, 2011), 94–111.
23. Wendy Cadge and Michael Skaggs, "How the Role and Visibility of Chaplains Changed Over the Past Century," *Interfaith America*, June 6, 2022, https://www.interfaithamerica.org/article/how-the-role-and-visibility-of-chaplains-changed-over-the-past-century/; Helen C. Orchard, *Hospital Chaplaincy: Modern, Dependable?* (Sheffield: Sheffield Academic Press, 2000), pp.127–35; and George Fitchett et al., "Spiritual Care: The Role of Health Care Chaplaincy," in *Spirituality, Religiousness and Health: From Research to Clinical Practice*, ed. Giancarlo Lucchetti et al. (Cham: Springer, 2019), pp.183–206.
24. Amy Lawton, "Religious Leaders Without Religion: How Humanist, Atheist and Spiritual-But-Not-Religious Chaplains Tend to Patients' Needs," *Religion News Service*, September 8, 2023, https://religionnews.com/2023/09/08/how-humanist-atheist-and-spiritual-but-not-religious-chaplains-tend-to-patients-needs/; and Pew Research Center, "Modeling the Future of Religion in America," September 13, 2022, https://www.pewresearch.org/religion/2022/09/13/modeling-the-future-of-religion-in-america/.
25. Stevenson, "Praying Along."
26. Richard P. Sloan et al., "Should Physicians Prescribe Religious Activities?" *New England Journal of Medicine* 342(25) (2000): 1913–16, https://doi.org/10.1056/NEJM200006223422513.
27. Richard P. Sloan, *Blind Faith: The Unholy Alliance of Religion and Medicine* (New York: St. Martin's, 2006).
28. Farr A. Curlin et al., "To Die, To Sleep: US Physicians' Religious and Other Objections to Physician-Assisted Suicide, Terminal Sedation, and Withdrawal of Life Support," *American Journal of Hospice & Palliative Medicine*, 25(2) (2008): 112–20, https://doi.org/10.1177/1049909107310141; and Farr A. Curlin et al., "Religion, Clinicians, and the Integration of Complementary and Alternative Medicines," *Journal of Alternative & Complementary Medicine* 15(9) (2009): 987–94, https://doi.org/10.1089/acm.2008.0512.

29. Debra B. Stulberg et al., "Abortion Provision among Practicing Obstetrician-Gynecologists," *Obstetrics and Gynecology* 118(3) (2011): 609–14, https://doi.org/10.1097/AOG.0b013e31822ad973; and Chelsey Yang, "The Inequity of Conscientious Objection: Refusal of Emergency Contraception," *Nursing Ethics* 27(6) (2020): 1408–17, https://doi.org/10.1177/0969733020918926.
30. Udo Schuklenk, and Ricardo Smalling, "Why Medical Professionals Have No Moral Claim to Conscientious Objection Accommodation in Liberal Democracies," *Journal of Medical Ethics* 43(4) (2017): 234–40, https://doi.org/10.1136/medethics-2016-103560.
31. Jason T. Eberl, "Protecting Reasonable Conscientious Refusals in Health Care," *Theoretical Medicine and Bioethics* 40(6) (2019): 565–81, https://doi.org/10.1007/s11017-019-09512-w; and Thomas D. Harter, "Why Tolerate Conscientious Objections in Medicine," *HEC Forum* 33(3) (September 2021): 175–88, https://doi.org/10.1007/s10730-019-09381-9.
32. For one of the original and paradigmatic examples of the public/private distinction that emerged during the Enlightenment, see Immanuel Kant, "Beantwortung der Frage: Was ist Aufklärung?" ["An Answer to the Question: What is Enlightenment?"], *Berlinische Monatsschrift* 12 (December 1784): 481–94.
33. Udo Schuklenk, "On the Role of Religion in Articles This Journal Seeks to Publish," *Developing World Bioethics* 18(3) (September 2018), https://doi.org/10.1111/dewb.12210.
34. Timothy F. Murphy, "In Defense of Irreligious Bioethics," *The American Journal of Bioethics* 12(12) (2012): 3–10, https://doi.org/10.1080/15265161.2012.719262; and Timothy F. Murphy, "The More Irreligion in Bioethics the Better: Reply to Open Peer Commentaries on 'In Defense of Irreligious Bioethics'," *The American Journal of Bioethics* 12(12) (2012): W1–W5, https://doi.org/10.1080/15265161.2012.746838.
35. Judah Goldberg and Alan Jotkowitz, "In Defense of Religious Bioethics," *The American Journal of Bioethics* 12(12) (December 6, 2012): 32–34, https://doi.org/10.1080/15265161.2012.719266; Rosie Duivenbode and Aasim I. Padela, "Contextualizing the Role of Religion in the Global Bioethics Discourse: A Response to the New Publication Policy of Developing World Bioethics," *Developing World Bioethics* 19(4) (2019): 189–91, https://doi.org/10.1111/dewb.12242; and Howard Brody and Arlene Macdonald, "Religion and Bioethics: Toward an Expanded Understanding," *Theoretical Medicine and Bioethics* 34(2) (2013): 133–45, https://doi.org/10.1007/s11017-013-9244-6.
36. Jennifer M. Stewart, "Faith-Based Interventions: Pathways to Health Promotion," *Western Journal of Nursing Research* 38(7) (2016): 787–89, https://doi.org/10.1177/0193945916643957; and Alice M. Kiger et al., "Faith Communities and the Potential for Health Promotion," *Oxford Research Encyclopedia of Communication* (May 24, 2017), accessed December 29, 2022,

https://oxfordre.com/communication/view/10.1093/acrefore/9780190228613.001.0001/acrefore-9780190228613-e-518.

37. Juliana van Olphen et al., "Religious Involvement, Social Support, and Health Among African-American Women on the East Side of Detroit," *Journal of Internal Medicine* 18(7) (July 2003): 549–57, https://doi.org/10.1046/j.1525-1497.2003.21031.x; Jeff Levin et al., "Religion, Health, and Medicine in African Americans: Implications for Physicians," *Journal of the National Medical Association* 97(2) (February 2005): 237–49; and Harold G. Koenig et al., *Handbook of Religion and Health*, 2nd ed. (Oxford: Oxford University Press, 2012).
38. Notably adhering to religious injunctions may include following rulings that allow for normatively proscribed treatments to be used under duress such as when no alternatives exist or certain death will ensue.
39. Al-Qaradaghi, "Formulating Ethical Principles."
40. Sohad Murrar et al., "Religious Accommodation or Professional Indoctrination? Experiences of Muslim Physicians in Academic Medicine," paper presented at Conference on Medicine and Religion, "Space for the Sacred in Care of the Sick," March 13–15, 2022, Portland, Oregon; Aasim I. Padela et al., "Religious Identity and Workplace Discrimination: A National Survey of American Muslim Physicians," *AJOB Empirical Bioethics* 7(3) (2016): 149–59, https://doi.org/10.1080/23294515.2015.1111271; and Benish Baqai et al., "Religious Identity Discrimination in the Physician Workforce: Insights from Two National Studies of Muslim Clinicians in the US," *Journal of General Internal Medicine* 38(5) (2023): 1167–74, https://doi.org/10.1007/s11606-022-07923-5.
41. Aasim I. Padela et al., "Religious Values and Healthcare Accommodations: Voices from the American Muslim Community," *Journal of General Internal Medicine* 27(6) (June 2012): 708–15, https://doi.org/10.1007/s11606-011-1965-5; Laila Azam et al., "Advancing Institutional Workforce Equity: Insights from Muslim Physicians in Academic Medicine," paper presented at the Academy for Professionalism in Health Care conference, "The Evolution of Professionalism in Health Care: Moving Towards an Interprofessional Future Celebrating 10 Years of APHC," Philadelphia, PA, June 1–3, 2022; and Aasim I. Padela et al., Azam, L., Murrar, S. and Baqai, B., "Muslim American Physicians' Experiences With, and Views On, Religious Discrimination and Accommodation in Academic Medicine," *Health Services Research* 58(3) (2023): 733–43, https://doi.org/10.1111/1475-6773.14146.
42. Amer Hamed et al., "The Impact of Keeping a Religious Beard in the COVID-19 Pandemic: An Online Cross-Sectional Survey Study Exploring Experiences of Male Medical Healthcare Professionals," *medRxiv* (2020). https://doi.org/10.1101/2020.11.01.20224022.
43. Todd K. Rosengart et al., "Open Heart Operations Without Transfusion Using a Multimodality Blood Conservation Strategy in 50 Jehovah's Witness Patients:

Implications for a 'Bloodless' Surgical Technique," *Journal of the American College of Surgeons* 184(6) (1997): 618–29; Vladimir Martyn et al., "The Theory and Practice of Bloodless Surgery," *Transfusion and Apheresis Science* 27(1) (August 2002): 29–43, https://doi.org/10.1016/S1473-0502(02)00024-1; and Lelio M. Sarteschi, "Jehovah's Witnesses, Blood Transfusions and Transplantations," *Transplantation Proceedings* 36(3) (April 2004): 499–501, https://doi.org/10.1016/j.transproceed.2004.02.013.

44. Aasim I. Padela, "Islamic Verdicts in Health Policy Discourse: Porcine-Based Vaccines as a Case Study," *Zygon* 48 (2013): 655–70, https://doi.org/10.1111/zygo.12036.

45. Gynecological Teaching Associates (GTAs) and Male Urogenital Teaching Associates (MUTAs) are individuals who use their own bodies to teach health professional learners how to perform breast, pelvic, urogenital, rectal, and/or prostate examinations. See Holly Hopkins et al., "Implementation and Utilization of Gynecological Teaching Associate and Male Urogenital Teaching Associate Programs: A Scoping Review," *Advances in Simulation* 6(19) (2021), https://doi.org/10.1186/s41077-021-00172-2.

46. The human body is judged to be sanctified and inviolable in both a living and dead state. This status of the body necessitates significant justification that definitive benefits will accrue by violating the integrity of the body. A straightforward example is that of surgery; permission is granted to violate one's bodily integrity, that is, disrupt its inviolability, when the proposed surgery carries significant benefits and/or the non-performance of surgery leads to significant harm. Many Islamic bioethics discussions, such as those concerning organ donation and transplant, revolve around discussions of bodily sanctity and inviolability, and posited harms and benefits. In this scenario, the same arises. Islamic jurists note the norm as preserving the sanctity and inviolability of the body, yet some permit the use of cadavers for medical teaching on the basis of posited benefits (*maṣalih*) from such learning and/or the dire necessity (*ḍarūrī*) nature of such study in order to acquire sufficient anatomical knowledge to be part of the medical profession. However, in light of alternative methods for learning anatomy, such as problem-based learning with prosection, living and radiological model-based learning, and computer-aided learning, that appear to be gaining traction and nearing the same curricular efficacy as dissection, a necessity-based argument may no longer hold. If the preservation of religion were the dominant moral objective around which medical education in the Muslim world was organized, one could argue that these alternative methods would be preferred and optimized so as to provide superior learning. For exemplar fatwas and some discussion of the matter, see "Donating Body Parts and Medical Use of Cadavers," Islamweb.net, July 9, 2002, https://www.islamweb.org/en/fatwa/84787/donating-body-parts-and-medical-use-of-cadavers; "Dissecting Dead Bodies in Order to Learn Medicine," *Islam Question & Answer*, January 26, 2007,

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8. Conclusion: The Perils and Promise of Integrating Maqāṣid in Biomedicine

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INDEX

Abdullah, 147
abortion, 83
academics, as consumers of Islamic bioethics, 74
actions of God, 114, 134
adab (virtue ethics-based) models, 74
ᶜ*adam* (negation) of the interest, 32
ᶜ*adāt* (human practices), 32, 59
adoption, 4
advocacy for *maqāṣid*-based bioethics, 138
AIDS, 80
Al-Azhar University, 119
alcoholism, 14
Al-Furqan Heritage Foundation, 1
Ali, Muna, 9, 11
allopathic healthcare, 18
alternative medicine practitioners, 17
Alzheimer's disease, 67
al-Āmidī, Sayf al-Dīn, 116, 119
analogical reasoning. *See qiyās*
Ancient Greece, 45
apostasy, 116, 118
archival research into *maqāṣid*, 130
Ashᶜari school of theology, 114
assisted dying, 84
assisted reproduction, 4
ᶜAtiyah, Jamal al-Din, 6, 29–30, 34–39
- building health policy from theory of, 63–65
- case of brain-dead pregnant woman, 92–93, 96
- comparison with al-Shāṭibī's model, 54–56
- conceptual extension of al-Shāṭibī's model, 81
- essential aspects of health, 53–54
- hierarchy of *maqāṣid,* 119
- inclusion of natural and scientific understandings, 103
- means of preserving life and mind, 50–51
- preservation of life, centrality of, 60–61

attained *(ḥuṣūlī)* knowledge, 143
al-Attas, Syed Naquib, 117
Attia, Gamal Eldin. *See* ᶜAtiyah, Jamal al-Din
Auda, Jasser, 81, 144
autonomy, as a value, 84
Ayurvedic medicine, 11

badness, theory of inherent, 114
balance, and health, 45
balancing tools in fiqh, 106
al-Bayḍāwī, Qadi, 116
Bayyah, Abdullah Bin, 147
beards, in medical settings, 126–127
Beauchamp, Tom L., 80, 101–102, 137
Bin Bayyah, Abdullah, 147
bioethics
- ambiguities in *maqāṣid*-based models, 96–99
- barriers to *maqāṣid* approach to, 137–39
- case of brain-death of pregnant woman
  - ——ambiguities in *maqāṣid*-based approaches, 96–99
  - ——conceptual extension analysis, 92–95
  - ——field-based redefinition analysis, 89–91
  - ——fiqh-based approaches to, 99–101
  - ——text-based postulation analysis, 95–96
- collective ijtihad, use of, 109
- deliberative model, 88
- discourse with Islamic world, 73–74

multidisciplinary approach, importance of to, 141–45
role of religion in, 5
suggested role for *maqāṣid* in, 105–110
biology, science of, 11
biomedicalization, 14–16
biomedicine
addressing societal problems through, 4–5
barriers to *maqāṣid* approach in contemporary bioethics, 137–39
dominance of, 12
engaging through *maqāṣid,* 19–20
health, conceptions of, 43–48
origins and definition of term, 9
philosophical underpinnings of, 10–11
and society, 9–14
biopolitics, 5
biopower, 5, 14
bioscience, 45
biotechnology, 79, 142
bloodless surgical techniques, 127
body, sanctity of, 82, 100–101
body parts, commodification of, 13
brain death
ambiguities inherent in *maqāṣid* approaches to, 96–99
blurred boundary between life and death, 4
conceptual extension, 92–95
controversies regarding, 88
field-based redefinition model, using to address, 89–91
fiqh-based approach to, 99–101
as legal definition of death, 98
test case of pregnant woman, 6
text-based postulation, using to address,95–96
brainwashing, 39, 53
al-Būṭī, Muḥammad Saʿīd Ramaḍān, 117
cadavers, problematic use of, 128
cannibalism, 120
capital punishment, 60–61
car accidents, protection from, 50, 61
catheters, 92
cause of death, 66
chaplains, 73–74, 100, 122–23
chemistry, science of, 11
childlessness, 4
Childress, James F., 80, 101–102, 137
China, 12, 17
Chinese medicine, 45
Christianity, medicine in, 45
chronic obstructive pulmonary disease (COPD), 67, 68–69
cleanliness, 34
clinical therapies, fiqh-based appraisal of, 100
clinicians, 73–75
clothing, 49
cochlear transplantation, 72
colonialism, 12
complementary medicine practitioners, 17
conceptual extension of al-Shāṭibī's method, 80–85
ambiguities inherent in, 97–98
case of brain-dead pregnant woman, 92–95
gaps in, 103–104
COPD (chronic obstructive pulmonary disease), 67, 68–69
cosmetic surgery, 80
COVID-19, 127
creativity, as a value, 84
criminality, 49
cultural barriers to *maqāṣid*-based bioethics, 137–39
cultural imperialism, 12

Darraz, Muhammad, 119
ḍarūrī (essential *maqāṣid*), 30–31, 34–35, 81
data, biomedical, 13
De Vries, Raymond, 16
death
  brain. *See* brain death
  data on, measuring population health with, 65–66
  defining, 94
  end-of-life healthcare, 84–85
death rates, 66
deliberative models, 20, 88, 131
dementia, 67
Deuraseh, Nurdeng, 85
diabetes, 67
diarrheal diseases, 67
dignity, preservation of, 39, 82, 84
disease
  biomedical approach to treating, 10–11
  data analytics, 13
  dominance of biomedical approach to, 12
  subjective aspects of, 12–13
diversity, as a value, 84
divorce, 50, 60
dominant probability *(al-ẓann al-ghālib),* 68
drowning, protection from, 50, 61
drug abuse, 15

Ebrahim, Abul Fadl Mohsin, 79–80
economy
  and health, 45
  life support and, 95
education, as a *maqāad,* 51
Emon, Anver, 42
end-of-life healthcare, 84–85
enhancing *maqāṣid. See taḥsīnī*
equality, as a value, 84
essential *maqāṣid. See (ḍarūrī)*
ethics. *See* bioethics
etiology of disease, 11
Europe, 45
Euthyphro dilemma, 114
exercise, physical, 69
existence of the interest *(ibqā'),* 32
experimentation, importance of in biomedicine, 10

faith-based healing systems, 18–19
family, *maqāṣid* pertaining to, 37, 39–40
fasting, 111, 118
fatwa, use of to resolve bioethical questions, 108–109
field-based redefinition of al-Shāṭibī, 76–80, 88, 89–91
  ambiguities inherent in, 96
  relativism, risk of in, 101–102
finance, in healthcare delivery, 13–14
fiqh (juristic) models, 74
  case of brain-dead pregnant woman, 99–101
  collective ijtihad, 109
  maqāṣid-based approach as complementing, 146–48
  role of in contemporary Islamic bioethics, 105–106
fire, protection from, 50, 61
folk sector, in healthcare systems, 17
Foucault, Michel, 5
freedom, as a value, 84
Al-Furqan Heritage Foundation, 1

genital examination training, 128
ghalabat al-ẓann (dominant probability), 68
Ghalia, Bouhedda, 79
al-Ghazālī, Abū Ḥāmid, 25, 32, 40–42, 116, 118
GHE (Global Health Estimates), 67
Global Health Estimates (GHE), 67

God, actions and will of, 114, 134
Gomaa, Ali, 58
goodness, theory of inherent, 114
Gould, Stephen Jay, 16
Greek medicine, 45
gun violence, 4

ḥājī (necessary) *maqāṣid,* 30–31, 34–35, 62, 64, 81
healers, 17
health
  biomedical conceptions of, 44–48
  commodification of, 13
  essential aspects of
  ——Attia's model, 53–54
  ——al-Shāṭibī's model, 52–53
  of population, measuring, 65–67
  social determinants, 56–57
  World Health Organization (WHO) definition, 46–47
health policy
  building from al-Shāṭibī's theory, 62–63
  building from Attia's theory, 63–65
  and *maqāṣid*, 59
  maqāṣid-based orientation, 67–70
  role of philosophers and theologians, 72
health policy register, 59
healthcare delivery
  bureaucracy in, 13
  ethical questions in modern era, 72
  preserving religion in, 120–21, 125–29
  religion, considerations of in, 111–12
  systems for, 16–19
heart disease, 67, 68–69
herbal treatments, 128
hierarchy *of maqāṣid,* 32–33, 61, 82–83, 115–20
ḥifẓ (preservation) of human interests, 32
high blood pressure, 69
higher objectives of Islamic law. *See maqāṣid al-Sharīᶜah*
ḥijāb, in hospital, 126–27
ḥikmah (wisdoms), 24–26, 41
honey, medical use of, 128
honor, preservation of, 38, 82
hospital chaplains, 73–74, 100, 122–23
hospitals, 55, 74
ḥuḍūrī (presential) knowledge, 143
human in, 111
human interests. *See (maṣlaḥah)*
human life *(nafs)*
  as essential *maqāṣid,* 31
  in field-based redefinition of *maqāṣid,* 77–79
  preservation of *(ḥifẓ al-nafs),* 32–33, 86
human reason. *See* reason, 140
human relations and transactions *(muᶜamalāt),* 59
humanities, in Auda's *maqāṣid* framework, 144
humanity, *maqāṣid* pertaining to, 38, 40
humility, importance of in multidiscipli-nary dialogue, 145–46
ḥurma (inviolability) of human body, 100–101
ḥuṣūlī (attained) knowledge, 143
hypertensive heart disease, 69–70
hysterectomies, 83

ᶜ*ibadāt* (worship), as domain of Islamic law, 32
ᶜ*ibadāt*-friendly (worship-friendly) hospitals, 128–29
Ibn ᶜAbd al-Salām, al-ᶜIzz al-Dīn, 35
Ibn ᶜAshur, Muhammad al-Tāhir, 40–43
Ibn Hindu, Abū Al-Faraj ᶜAlī, 47
Ibn Taymiyyah, 116
ibqā' (existence of the interest), 32

ijtihad, collective, 109
ᶜ*illah* (pl. ᶜ*ilal*) (rationale), 24–26, 41
illness
  faith-based responses to, 18–19
  respecting religious commitment of patient, 125–26
imams, as consumers of Islamic bioethics, 74
Indian medicine, 45
individuals, *maqāṣid* pertaining to, 37–38
induction method for deriving *maqāṣid,* 27–29
industrialization, impact on functional health, 45
inferential analysis, 28
infertility, 78, 103
intellect *(*ᶜ*aql)*
  as essential *maqāṣid,* 31
  in field-based redefinition of *maqāṣid,* 77–78
  preservation of *(ḥifẓ al-*ᶜ*aql),* 32–33, 50, 53
intellectual property, 102, 132
intensive care, 72, 98
  See also brain death
International Institute of Advanced Islamic Studies, Malaysia, 1, 130
intoxicants, 38, 51, 53
inviolability *(ḥurma)* of human body, 100–101
Iran, 138
ischemic heart disease, 67, 68–69
Islam
  biomedical discourse within, 73–74
  brain-death, positions on, 88
  conception of life and death, 94
  engaging biomedicine through *maqāṣid,* 19–20
  interest in *maqāṣid al-Sharī*ᶜ*ah* in contemporary thought, 21–23
  maqāṣid defined, 23–26
  See also religion (*dīn*)
Islamic bioethics. *See* bioethics
Islamic Institute for Development and Research and Maqasid Institute, 1
Islamic jurists, as producers of Islamic bioethics, 75
Islamic law
  four domains of, 32
  sources for derivation of, 23–24
istidlāl (rational inference), 28, 41
istiṣlāḥ, 41
istiḥsān, 41

Jehovah's Witness patients, 127
jihad, 116–18
jināyāt (criminal law)
  as domain of Islamic law, 32
  importance of *maṣalih* and *maqāṣid* in, 59
Jumah, Ali, 58
*Jumu*ᶜ*ah* service, 126
juridical academies, 75
justice, 40, 49, 133–35
al-Juwaynī, 28

kalām jadīd in Setia's approach, 145
Kamali, Mohammad Hashim, 43, 130–31
karāma (sanctity) of human body, 100–101
Kasule, Omar, 6, 77–80, 89–90, 96, 102
kidney disease, 67
Kleinman, Arthur, 11, 14
knowledge
  as relational and perceptive, 141–42
  as a value, 84
  world-oriented vs presential, 143
Krieger, Nancy, 10
Kuhnian paradigm, 9

leadership, role of in preserving life, 49–50
legal hermeneutics, 28

legislators, as consumers of Islamic bioethics, 74
life
compared with preservation of religion, 115–20
conceptual uncertainties in definition of, 132
in field-based redefinition of *maqāṣid,* 77–78
in *maqāṣid*-based approaches to health policy, 59–61
preservation of, 7, 38, 49–51, 60, 82–83
sanctioned taking of, 116
life expectancy, 65–66
life support
ambiguities in *maqāṣid* approach to, 96–99
conceptual extension analysis of, 92–95
field-based redefinition analysis, 89–91
fiqh-based approach to, 99–101
text-based postulation analysis of, 95–96
linguistic analysis, 28
love, as a value, 84
lower respiratory infections, 67, 68–69
lung cancer, 67, 68–69

mā dūn al-ḍarūrī category in Attia's model, 36
mā warā' al-taḥsīnī category in Attia's model, 36
Malaysia, 128, 130
Mālikī school of law, 28, 41
maqāṣid al-Sharīʿah
ambiguities in frameworks based on, 96–99
ʿAtiyah's supplementary methods for deriving, 29–30
caution among classical jurists with use of, 42
as complementing fiqh-based, 146–48
conceptual uncertainties in, 132
conflict with fiqh-based approaches, 99–101
contemporary study of, 1–3
creeping expansion of in contemporary discourse, 133–35
defining, 23–26
deriving, through induction, 27–29
engaging biomedicine and healthcare through, 19–20
five phases of research into, 130
and health policy, 59–61
health policy orientation, 67–70
hierarchy of, 32–33, 61, 82–83, 115–20
implementing, problems with, 135–37
interest in, 21–23
in maintaining religious oversight over modern life, 3–4
methodological problems in bioethics, 101–105
moral obligations attached to, 131–35
multidisciplinary analyses, as strategy for implementing, 141–45
in policy-making, 20–22
preservation of life and religion, 7
relativism, risk of, 101–102
al-Shāṭibī's theory of, 30–34
al-Shāṭibī and ʿAtiyah's models compared, 34–39
suggested role for in Islamic bioethics, 105–110
use of in modern issues, 58
marriage, 49, 60
maṣlaḥah mursalah, 28, 62
maṣlaḥah (human interests), 24–26, 41, 59, 83

as fundamental goal of God's commands, 113
hierarchy of, 115–17
problematic contemporary redefinitions of, 132–34
restoring Qur'an as primary source for, 140
material wealth *(māl)*
as essential *maqāṣid,* 31
in field-based redefinition of *maqāṣid,* 77–78
preservation of *(ḥifẓ al-māl),* 32–33, 38
societal wealth, 78, 89–91, 96, 98, 102
Matūridī school of theology, 114
medical training, catering for religious beliefs in, 128
Middle Ages, 45
mind, consideration of, 38, 51, 53
morality, Islamic theological theories on, 114–15
morbidity
importance of as population health marker, 66
limiting, to reduce mortality, 63
use of vaccinations, 59
mortal dangers, 50–51, 53, 60, 61, 82
mortality
addressing causes of, 63, 65
obligation on societal leaders to address, 67
muʿamalāt (human relations and transactions), 32, 59
multidisciplinary analyses, 141–46
multi-level analysis
in bedside concerns, 110
in implementing *maqāṣid,* 136
in Islamic bioethical discourse, 73
in reforming medical ethics, 108
murder, criminalization of, 49, 53
Muslim community *(ummah), maqāṣid* pertaining to, 37, 40
Muslim patients, as consumers of Islamic bioethics, 74
Muʿtazilite school of theology, 114
al-Muwafaqqāt (al-Shāṭibī), 27

nafs. See human life
natural sciences, in Auda's *maqāṣid* framework, 144
naturalism, 10
nature *(khalq),* protecting, 83, 103
necessary *maqāṣid. See ḥājī*
neonatal mortality, 66, 67
nonoverlapping magisteria, 16
Nyazee, Imran Ahsan Khan, 111

objective criterion, in Attia's model, 37, 64
objectives of Islamic law. *See maqāṣid al-Sharīʿah*
Opwis, Felicitas, 42
organ donation, 111

Padela, Aasim I., 74–75
Pakistan, 138
palliative care, 84–85
patient-centered healthcare, 5
patients, as consumers of Islamic bioethics, 74
peace, world, 40
peace *(salām),* protecting, 40, 83
personal piety, 38–40, 82
pharmaceutical industry, 12
philosophy, role in health policy, 72
piety, 38–40, 82
policy-making
in Attia's means-focused model, 34–39
barriers to *maqāṣid*-based approach, 137–39
as based on particular ontological schema, 10
biomedicalization in, 15

health, biomedical conceptions of, 43–48
health policy (*See* health policy)
legislators as consumers of Islamic bioethics, 74
maqāṣid, use of in, 20–22
social determinants of health, 56–57
popular sector, in healthcare systems, 17
population health, measuring, 65–67
post-colonial period, 21
prayers
in hospital, 126
shortening on a journey, 26, 34
pregnancy, case of brain-death during, 88ff
presential *(ḥuḍūrī)* knowledge, 143
private life, sanctity of, 82
procreation, 52, 77–78, 103
productivity measures of physicians, 13–14
professional sector, in healthcare systems, 17
progeny *(naṣl)*
as essential *maqāṣid,* 31
in field-based redefinition of *maqāṣid,* 77–78
preservation of *(ḥifẓ al-naṣl),* 32, 38, 39–40
Prophet Muhammad, 117–18
psychiatry, 13
public square, 122, 124

al-Qaradaghi, Ali, 125–26
al-Qaradawi, Yusuf, 81
al-Qarāfī, 39
qiyās (analogical reasoning), 23–25, 64
in al-Ghazālī's *maqāṣid* framework, 40–41
Qur'an
Auda's approach for analyzing for *maqāṣid,* 144
on capital punishment, 60–61
on honey as medical treatment, 128
restoring primacy of in discussion of human interest, 140
sacredness of life in, 60, 63
as source of Islamic law, 23

radiation, 53
radioactive materials, 9
Ramadan, Tariq, 6, 81, 83–85, 92, 94, 97–98, 103
Ramadan fast, 111
reason
importance of in Attia's theory, 63–64
preservation of, 38
reliability of in discerning good, discussion of, 134
role of in discerning human interests, 140
as unreliable source of morality, 114
use of to identify secondary objectives, 28
reductionism, tendency of biomedicine towards, 10, 12
reformation movements, 21–22
relative value units (RVUs), 14
relativism, risk of in *maqāṣid* approach, 101–102
religion *(dīn)*
in bioethics, 5
conceptual uncertainties around, 132
considerations in a healthcare system, 111–12
as essential *maqāṣid,* 31
evolution of, with societal changes, 58
faith-based healing systems, 18–19
and medicine, 45
preservation of, 7, 38, 61, 82
preserving in healthcare, 120–21, 125–29

priority of, compared to life, 115–20
preservation of *(ḥifẓ al-dīn),* 32–33
religious healers, 17
religious holidays, 127
reproduction, assisted, 4, 103
Research Center for Islamic Legislation and Ethics, Qatar, 1
respiratory infections, 67, 68–69
revivalist movements, 21–22
Riphah International University, Pakistan, 1
ruqyah healing, 128
RVUs (relative value units), 14

Saifuddeen, Mohd, 78–79, 102
salt, regulation of, 69
sanctity *(karāma)* of human body, 100–101
Saudi Arabia, 138
secondary objectives, 28
secularism, 106, 121–24, 137, 144
security, 40, 61
Setia, Adi, 117, 145
sexual misconduct, 50, 60
sexual reputation, 39
Shāfiʿī school of law, 28, 41
shared responsibility, 40
Sharīʿah law
countries that use as source of law, 138
fundamental goal of, 113–14
maqāṣid of (*See maqāṣid al-Sharīʿah*)
al-Shāṭibī, Abū Isḥāq
building health policy from theories of, 62–63
comparison with ʿAtiya's model, 34–39, 54–56
essential aspects of health, 52–53
hierarchy of human interests, 115–17
induction method for deriving *maqāṣid,* 27–30
life, approach to preserving of, 49–50
preservation of life, centrality of, 60
preservation of religion, 61
reconciling with Attia's prioritization of life over religion, 119
reformulation of theories of:
——conceptual extension approach, 80–85
——field-based approach, 76–80, 89–91
——text-based postulation method, 85–87
secondary objectives, role of, 102
theory of *maqāṣid al-Sharīʿah,* 30–34
use of *maqāṣid* formulae of, 6
shelter, 49
slander, 39
smoking, 68–69
social determinants of health, 56–57
social sciences
in Auda's *maqāṣid* framework, 144
as source of Islamic bioethics, 75
society
adaptation of religion to changes in, 58
biomedical approaches to problems in, 4–5, 9–16
leadership, role of in preserving life, 49–50
maqāṣid pertaining to, 37, 40
societal wealth, 78, 89–91, 96, 98, 102
solidarity, as a value, 84
soul, 94
starvation, 53, 60
state authorities, as producers of Islamic bioethics, 75
statistical data, use of in policymaking, 66–67
sterilization, prohibition of, 80
stroke, 67, 68–69
suicide, 61

Sunnah
  sacredness of life, 60
  as source of Islamic law, 23
surgery
  cosmetic, 80
  fiqh-based appraisal of, 100

*taḥsīnī (*enhancing) *maqāṣid,* 31, 34–35, 62, 64, 81
technology, in biomedicine, 11, 142
teleology, 13
text-based postulation of al-Shāṭibī's method, 85–87
  ambiguities inherent in, 97
  case of brain-dead pregnant woman, 95–96
  restrictions of, 103–104
theologians, role in health policy, 72
theology of morality, 114–15
therapeutics, respecting religion in, 125–26
trachea, 67, 111
transplantation, 111
travelling, exemption from fasting while, 118
al-Ṭūfī, Najm al-Dīn, 39, 42

ummah. See Muslim community
United States
  economic dimension of health, 45
  productivity measures of physicians in, 13–14
uṣūl al-fiqh
  and the *maqāṣid framework,* 40–43
  use in *Sharīᶜah*-based legislation, 138
  use of in Attia's framework, 64
  using in parallel with *maqāṣid* framework, 146–48
  using to identify *ᶜillah,* 28

vaccination, 59, 127
ventilation, life sustaining, 72, 92

warfare, 116–18
wealth. *See* material wealth
welfare, as a value, 84
Western countries, 12
WHO. *See* World Health Organization
will of God, 114, 134
World Health Organization (WHO), 46–47, 66–67
world-oriented knowledge, 143
worship *(ᶜibadāt),* preservation of, 77–78, 85

zam zam water, 128
al-ẓann al-ghālib (dominant probability), 68

Written by a uniquely positioned scholar, this book addresses a notable gap in scholarship by exploring links between the maqāṣid al-Sharīʿah and contemporary healthcare. Discussions about maqāṣid have become prevalent within Muslim public, professional, academic, and policy circles, as they are seen as means to bridge the classical tradition with modern exigencies. Accordingly, this book critically engages with maqāṣid thought in relation to the concepts, goals, practices, and social structures of biomedicine, highlighting both the potential and limitations of current approaches. It aims to inspire an interdisciplinary dialogue, motivating scholars to refine maqāṣid theories, update implementation frameworks, and conduct applied research to address contemporary bioethical challenges. By addressing questions about the relevance of maqāṣid to health and societal well-being, and their potential to inform healthcare practices and policies, the book lays essential groundwork for scholarly engagement at the intersection of Islamic law and biomedicine.

AASIM I. PADELA is a bioethicist, community health researcher, and emergency medicine clinician. As a multidisciplinary academic scholar, Dr. Padela holds an MD from Weill Cornell Medical College, an MSc in Healthcare Research from the University of Michigan, a BS in Biomedical Engineering, and a BA in Classical Arabic from the University of Rochester. His formal training includes a residency in emergency medicine at the University of Rochester, a health services research fellowship at the University of Michigan, a medical ethics fellowship at the MacLean Center for Clinical Medical Ethics at the University of Chicago, and an Islamic theology & law fellowship at the Oxford Center for Islamic Studies.

Offers a reading of the maqāṣid in conjunction with modern biomedicine…suggest(ing) detailed strategies yet also (noting) many challenges that the integration of religious values of maqāṣid into the secularist agenda of modern biomedicine would present. **PROFESSOR MOHAMMAD HASHIM KAMALI**

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ISBN 979-8-89193-228-9