MAQASID AL-SHARIAH AND BIOMEDICINE

BRIDGING MORAL, ETHICAL, AND POLICY DISCOURSES

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Aasim I. Padela

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P.O. Box 126, Richmond, Surrey, TW9 2UD, UK • www.iiituk.com

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ENDORSEMENTS

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.

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.

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.

ENDORSEMENTS

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.

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.

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.

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.

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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-Sharīᶜah*, and why are they relevant today? The term *maqāṣid al-Sharīᶜah* 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-Sharīᶜah* 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-Sharīᶜah* refers to a set of connected theories, frameworks, and catalogs of human interests associated with Islamic law.

Most certainly, the *maqāṣid al-Sharīᶜah* are a current 'hot' topic, and this heightened interest is informed by many historical, practical, and social factors. Notably, many view the *maqāṣid al-Sharīᶜah*, 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-Sharīᶜah* 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-Sharīᶜah* 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-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? 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-Sharīᶜah* 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-Sharīʿah*. I describe what the *maqāṣid* represent, define key terms and concepts of this Islamic ethico-legal theory, and summarize the *maqāṣid al-Sharīʿah* 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 ʿAtiyah (b. 1928 CE), a contemporary Islamic legal theorist.

Chapter 3 tackles theory: I use the *maqāṣid* formulae of al-Shāṭibī and ʿAtiyah (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-Sharīʿah* 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-Sharīᶜah* 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-Sharīᶜah* 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-Sharīʿah*.

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-Sharīʿah*. 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.