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Correspondence

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*)"

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Our target article aimed to advance professional conversations and multidisciplinary engagement regarding the ethics of end-of-life care from an Islamic perspective. If the open commentaries are any indication, our monograph will have its intended effect. We sought to provide actionable guidance to Muslim providers struggling with conversations regarding goals of care and with decisions to withdraw or withhold life support near the end of life. Data from our recent national survey of American Muslim physicians demonstrates that this provider community struggles with end-of-life care decisions. For example, 70% (173/246) of respondents found it psychologically difficult to withdraw life-sustaining treatment and 46% (114/246) did not view brain-dead criteria and cardiopulmonary criteria to be equivalent markers of death ("Initiative on Islam & Medicine" 2014). While Muslim physicians—as well as Muslim patients, families and religious leaders—often seek out religious resources to assist their end of-life care deliberations, often the extant literature may not account for bedside realities (Padela, Shanawani, and Arozullah 2011). To fill this gap, one of us (AIP) co-convened an academic conference that brought allied health professionals, Islamic scholars and religious leaders, social scientists, and bioethicists together to launch a multidisciplinary dialogue regarding end-of-life care. (Padela 2013; "Where Religion, Bioethics, and Policy Meet" 2011). Our article continues in the tradition of the conference to advance applied Islamic bioethics discourse. At the article's outset we conceded that "refinement in [our Islamic bioethical] theory and corresponding framework is likely to occur in response to interlocutor critique and subsequent deliberation" (Padela and Mohiuddin 2015, 11). We thank the reviewers and commentators for joining us in an ongoing critical conversation and prodding us to reconsider aspects of our theoretical framework. We respond here to the commentaries in broad strokes by addressing themes that cut across multiple pieces.

RESPONDING TO CRITIQUES OF THE USAGE OF *MUKALLAF* STATUS AS A MARKER OF QUALITY OF LIFE AND A THERAPEUTIC END GOAL

Several commentators disagreed with our proposal for *mukallaf* potential as a therapeutic end goal for end-of-life

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care treatment (Al-Khafaji et al. 2015; Alnakshabandi and Fiester 2015; Emran 2015; Rady and Verheijde 2015). We suggest that treatments that restore a patient's *mukallaf* potential should be classified as lifesaving because we view *mukallaf* potential to represent a life with optimal quality. An optimal quality of life is one where one can willfully engage in actions that benefit one's afterlife (if one believes in an afterlife and so chooses). Because a person with *mukallaf* potential has the intellectual capacity to weigh the benefits and harms of actions, the person can engage in such deliberation. Non-Muslims with the mental capacity to recognize the harms/benefits of actions are considered to have *mukallaf* potential, as are children who are not yet intellectually mature. For a Muslim, the onset of puberty transforms *mukallaf* potential into *mukallaf* status and activates liability for religious obligations. The foremost of such obligations are the obligations to God, *huquq* Allah, and the primary duty of knowing God is attested to by performing prescribed worship rituals. While *mukallaf* status is a general category, there are gradations to mental capacity that make one morally culpable for certain actions and not others, a point we return to shortly. We argued that a Muslim physician is morally obligated to provide treatment that assists a patient to regain *mukallaf* potential (provided the patient formerly had *mukallaf* potential). And the physician is not obligated to continue medical treatment where *mukallaf* potential cannot be restored (provided the patient formerly had *mukallaf* potential). We derive the moral liability of a Muslim physician by adapting a categorization schema devised by classical Islamic jurists to determine when a Muslim patient is obligated to seek treatment by mapping out corresponding obligations upon the Muslim physician to provide treatment.

Commentators critiqued our use of the *mukallaf* construct in four ways. First, several commentators pointed out that a person without the cognitive capacity to be a *mukallaf* may nonetheless gain afterlife rewards (Al-Khafaji et al. 2015; Alnakshabandi and Fiester 2015; Emran 2015). Because we argue that a life of optimal quality is one with the potential to volitionally affect one's afterlife, represented by *mukallaf* potential in our framework, commentators suggest that the posited basis for using the *mukallaf* construct is flawed given that non-*mukallafs* can also gain afterlife rewards. Three commentaries cite narrations of the Prophet Muhammad that describe rewards for the ill because of the pain and suffering they experience as evidence for their claim that a patient whose mental capacity cannot be restored to enable *mukallaf* potentiality can still benefit her afterlife (Al-Khafaji et al. 2015; Alnakshabandi and Fiester 2015; Emran 2015). While the Prophetic statements do not address *mukallaf* status and how that relates to the rewards received on account of being ill, we nonetheless agree that a non-*mukallaf* individual can gain afterlife rewards. These rewards, however, are not procured as recompense for action; rather they are interpreted as part of divine mercy. According to Islamic theology, God's mercy extends to all of creation, animate and inanimate, *mukallaf* or non-*mukallaf*, as the Qur'an proclaims the divine voice to declare "My mercy embraceth all things" (7:156) ("The Meaning of the Glorious Qur'ân" 2014).

The mental capacity required for *mukallaf* potential is the capacity that makes one morally accountable and able to weigh the benefits and harms of one's deeds; it is what allows for willful action. The individual without such capacity, accordingly, has no moral accountability because without the capacity for moral action there can be no moral obligation. An individual who loses the mental capacity required to be a *mukallaf* cannot *willfully* affect her afterlife and has no obligations before God. We maintain that such a state represents a diminution in quality of life for one who formerly maintained *mukallaf* potential.

Insofar as the ill may receive afterlife benefit, some commentaries suggest that it remains a physician's ethical obligation to continue treatment even if therapy cannot restore the patient's mental capacity for willful action. We find this position problematic because medical interventions may cause pain and distress. A categorical obligation to impose medical intervention with this possibility appears to run counter professional responsibilities to relieve pain and suffering. Furthermore, such action appears to trample upon the non-*mukallaf*'s intrinsic human dignity and bodily sanctity. The Islamic analogues to intrinsic human dignity and human sanctity, *karāma* and *ḥurma*, extend to all humans irrespective of state (encompassing the dead as well). It may be contrary to these ideals, as well as contradictory to the Prophetic command—a core element of Islamic ethico-legal philosophy—that "there should be neither harming nor reciprocating harm" ("40 Hadith Nawawi, Hadith 32" 2014) to mandate that the physician impose on the patient interventions that may disrupt bodily integrity or cause pain and suffering if the intended purpose is to sustain only physiological markers of life (the intellectual capacity for willful action not being able to be restored) because of possible afterlife rewards accrued on account of belonging to the category of ill covered by the Prophet's statements.

A second criticism leveled at our usage of the *mukallaf* construct was that the construct itself, or our explanation of it, was tied it too closely to ritual worship. Recall that a *mukallaf* becomes liable for religious obligations, chief among them being ritual acts of worship. Referring to Qur'anic verses that indicate that the entire cosmos glorifies God (17:44, 24:41, 59:24, 61:1, 62:1, 64:1), several commentators suggest that a broader understanding of worship would counter our reliance on the *mukallaf* construct as an indicator of optimal quality of life because even non-*mukallaf*s, and in this case the inanimate, "worship" God (Al-Khafaji et al. 2015; Emran 2015; Rady and Verheijde 2015). Drs. Rady and Verheijde quote a different Qur'anic verse to demonstrate that non-*mukallaf*s can remember God to similarly argue that remembrance of God equates to worship and thereby *non-mukallafs* may also worship God. In a somewhat analogous line of argumentation against *mukallaf* potential denoting a life of optimal quality, these commentators assert that because

worship activities are rewarded, *non-mukallafs* have lives with intact quality because they too can gain afterlife rewards for remembering and glorifying God. As a result, the commentators suggest our usage of the *mukallaf* construct as a marker of quality of life is obviated and the worship definition we used is too restrictive. We have discussed the accrual of afterlife rewards related to non-*mukallaf*s earlier and how this fact does not destabilize our use of the *mukallaf* construct. We concur that the Qur'an notes that all of creation glorifies/remembers Him but also reminds readers that the Qur'an tells us that humankind bound itself to a covenant of obedience whereby good deeds would be rewarded and evil ones punished (33:72) ("Quran Tafsir Ibn Kathir" 2014), and that this special covenant was not borne by the inanimate creation. It is a result of this pact that humankind becomes morally accountable and becomes obligated to discharge religious duties (Nyazee 2000, 110); this covenant undergirds the *mukallaf* construct. The Qur'an unequivocally describes the worship as the purpose of humankind's creation (51:56) and commands humankind to establish ritual prayer as a specific form of remembering God (20:14). And in our article we describe how the first thing accounted for on the Day of Judgment is the ritual prayer. Consequently, the ritual forms of worship are a specific obligation placed upon humankind, the primary means by which humans remember and glorify Him, and a means of reward in the afterlife. Glorification and remembrance of God are practices related to ritual worship but do not equate to or relieve one from the obligation for ritual worship.

We want to clarify that *mukallaf* status signifies much more than the ethico-legal capacity/liability for ritual worship; it also comprises the capacity to undertake and be morally liable for civic duties and financial affairs, such as executing a contract or disposing of property. Consequently, all of an individual's activities, not just ritual worship, are opportunities to gain afterlife reward and a *mukallaf* is morally accountable for all her deeds. As we mention in our article, the theological *mukallaf* construct, signifying accountability, is closely related to the concept of *ahliyyah*, legal capacity in Islamic law (Arabi 2013; Nyazee 2000, 110). Legal capacity is of two types: *ahliyyah al-wujūb* and *ahliyyah al-adā*. *Ahliyyah al-wujūb* is the ability of a human being to acquire rights and obligations and this ability derives from being a human. *Ahliyyah al-adā* is the capacity for execution and performance of duties and can be further subdivided into three categories: the capacities related to (i) criminal liability, (ii) civil/financial liability and (iii) liability for acts of ritual worship (Nyazee 2000, 112). While mental/intellectual maturity is a precondition to *mukallaf* potential (and consequently *ahliyyah al-adā*), the mental faculty has gradations such that one can be morally culpable for some acts but not others. We highlighted the linkage of *mukallaf* with liability for ritual prayer in our article because it underscores the minimum of what God requires of a Muslim, and because ritual prayer may require a lesser degree of mental acuity than engaging in financial transactions in accordance with Islamic regulations. Accordingly, preserving mental functioning to allow for *mukallaf* potential, even if only in its ritual worship dimension, is a moral obligation for the Muslim physician. We further chose to use the *mukallaf* theological construct in our framework rather than the legal *ahliyyah al-adā* construct because it has broader significance, is wider in scope, and may be more suited for future revisions in our theory (Padela and Mohiuddin 2015).

The third reason suggested for abandoning *mukallaf* potential as a therapeutic end goal and the basis upon which a Muslim physician can judge his ethical obligations in end-of-life care for patients is that it would deny clinical therapeutics to patients whose clinical status is not physiologically futile (Rady and Verheijde 2015), and to the elderly (Alnakshabandi and Fiester 2015). Drs. Alnakshbandi and Feister (2015) remark that "reliance on this concept in the context of medical care would undercut the rationality of continued treatment for any and all patients who become brain-injured, who have even mild dementia (if it compromised the patient's ability to do religious or moral acts), or who have a significant cerebrovascular accident—even if those patients are not near the end-of-life" (25–26). To illustrate their point the authors present a clinical vignette of an 80-year-old Muslim patient with diabetes and dementia who while forgetful regarding prayer and fasting spends quality time with his family. Were such a patient to fall ill, Drs. Alnakshbandi and Feister believe that our ethical framework would find the Muslim physician is not obligated to treat the patient. Before analyzing the case vignette according to our posited framework, we must clarify the mental capacity prerequisite to *mukallaf* potential. Mental/intellectual maturity is a precondition to *mukallaf* status. In the Islamic ethico-legal tradition the mental faculty or intellect, *'aql*, develops in stages, beginning with the stage of *tamyīz* and ending at *rushd* (Abd-Allah 2012). *Tamyīz* refers to the intellectual ability to distinguish between similar things, while *rushd* implies the fullest degree of intellectual moral capacity allowing one to determine, and then incline toward, actions that maximize worldly and afterlife benefits. The minimal level, or minimal capacity, of intellect needed for *mukallaf* potential is the ability to weigh the relative harms and benefits of actions in a general sense (Abd-Allah 2012). It is the capacity to assess benefits/harms, and not the precision of the intellectual faculty, that confers *mukallaf* potential. The determination of requisite intellectual capacity for *mukallaf* status is a subjective and qualitative assessment, and an individual can have legal capacity to be liable for certain acts but not for others.

In the case vignette we find a Muslim who prays when reminded and attempts to fast in Ramadan. The fact that the patient performs acts of worship volitionally may indicate that the patient has the mental capacity to recognize the posited afterlife benefits of prayer and fasting. At face value he appears to have sufficient mental status, even if it is rudimentary and subject to declination, to have *mukallaf* status. The fact that the patient is forgetful is of no consequence because habitual forgetfulness is a valid excuse for

not performing acts of worship (Nyazee 2000, 128; "Sahih Al-Bukhari Vol. 1, Book 10, Hadith 571" 2014; "40 Hadith Nawawi, Hadith 39" 2014), and fasting is not required of those who are physically unable to do so (Rispler-Chaim 2006, 28–30). Additionally, the illness that befalls the patient, bacteremia, when treated appropriately, is not expected to threaten his cognitive capacity to have *mukallaf* status. Even if the acute illness led to temporary cognitive decline (through diabetic ketoacidosis, for example), the clinical therapeutics required (antibiotics, insulin, intravenous fluids, and intensive care unit [ICU] care) can be reasonably expected to assist the patient in regaining his mental capacity for *mukallaf* status. Therefore, a Muslim physician is ethically obligated to provide these treatments because they would help restore quality of life.

If the patient in question instead was not expected to regain his mental capacity for *mukallaf* potential with advanced therapeutics we suggest that end-of-life care decision making must account for the fact that the patient has diminished quality of life and a Muslim physician is not Islamically obligated to initiate or continue such treatment. This latter position appears to unsettle several commentators (Al-Khafaji et al. 2015; Alnakshabandi and Fiester 2015; Emran 2015). We must clarify that our framework does not state that the Muslim physician *must not* apply advanced therapeutics; rather it asserts that there is no obligation (it is not *wājib* or *farḍ*) to do so. In other words we suggest that there is no sin attached to forgoing such advanced treatments. All else being equal, withholding/withdrawing advanced treatments or continuing/initiating such therapeutics appear to be in the realm of permissible (*mubāḥ*).

Drs. Alnakshbandi and Feister cite scriptural sources that indicate being merciful to the elderly and being righteous to one's parents as evidence for Muslim physicians' obligations to treat patients with diminished mental capacity. The authors, however, do not specify what the goal of care would be at the end of life for such patients. We do not deny that caring for the elderly is an important Islamic value, but caution against the conflation of being dutiful to one's parents, showing respect (to) our elders, and relieving hardships of this worldly life as stated by the verses and hadith quoted by the commentators with "medical care" (Alnakshabandi and Fiester 2015). These scriptural sources do not specifically concern medical care nor do they address professional ethical obligations; rather, the texts address the general community and provide general moral teachings. We further caution against deducing Islamic moral duties and obligations without employing the *uṣūl al-fiqh* methodologies. Islamic jurists, experts in deriving ethico-legal injunctions from scriptural source texts, both from the classical and modern area and from across the Sunni schools of Islamic law, do not endorse a categorical ethico-legal obligation to seek medical care, and accordingly do not endorse a categorical ethico-legal duty upon the Muslim physician to provide medical treatment in every case (Ghaly 2010; Albar et al. 2007; Yacoub 2001; Ebrahim 2008).

Drs. Rady and Verheijde offer "physiologically effective palliation [that] … alleviates distress" (15) as a treatment end-goal instead of the restoration of *mukallaf* potential. Unfortunately, the strength of correlation between physiological measures and subjective experiences of suffering in a patient with severely diminished neurological capacity is unknown. We maintain our concerns regarding the potential disrespect for *karāma* and *ḥurma* if the goal of care is to maintain/stabilize a patient's vital signs if there is no possibility of neurological recovery sufficient for *mukallaf* potential. We agree with Drs. Rady and Verheijde that "distinguishing between a person at the end of life and an imminently dying person is relevant" (15) when assessing the moral obligations of the physician. We have already demonstrated that the Muslim physician has an ethical obligation to treat towards the restoration of *mukallaf* potential, and when that is not possible maintaining clinical therapy must be ethically assessed based on a myriad of factors including the relative benefits and burdens of treatment, the relationship between the treatments and maintenance of the *karāma* and *ḥurma* of the human, the patient's prior wishes or surrogate decision makers' desires, and standard medical practice. In an imminently dying patient, it is conventional to offer therapeutics for reducing discomfort during the dying process. Such a practice may be validated by the Islamic ethico-legal construct of *'urf*, custom, which provides a basis for ethico-legal assessment in the absence of any contravening source text. According to *uṣūl al-fiqh,* when an action is evaluated as part of *'urf*, in other words, the ethico-legal argument for the action in question is sourced within *'urf*, that action can be elevated to the status of recommended but does not gain the status of an ethicolegal obligation, *wajib* or *farḍ*, unless scriptural source texts specifically substantiate the practice. We concede that it may be recommended for a Muslim physician to provide "physiologically effective palliation" (15) even when it does not contribute to the restoration of *mukallaf* potential.

The fourth reason given for abandoning *mukallaf* potential as a goal of end-of-life care is that according to Drs. Alnakshbandi and Feister, it "places the judgment of a patient's moral worth in the hands of physicians. God is the only decider and determiner of who is *mukallaf*" (Alnakshabandi and Fiester 2015, 26). Physicians routinely assess the effectiveness of clinical therapy and the likelihood of achieving specific clinical outcomes with that therapy. In advising families and patients about courses of treatment physicians commonly make value judgments related to potential quality of life in light of these medical "facts." The mere adding of a religious dimension to these prognostic exercises and using a religious term, *mukallaf* potential, to signify a level of neurological functioning do not fundamentally change the type of decision-making processes physicians routinely engage in. Additionally, judges and juries often deliberate over the cognitive abilities of individuals to assess culpability when they commit crimes, as well as when deciding whether

mentally disabled individuals can engage in contractual transactions. In an Islamic legal system such activities represent an assessment of *mukallaf* status because these individuals are standing before sacred law. Therefore, determining cognitive capacity and moral accountability by humans has precedent in both the Islamic and the secular legal system.

RESPONDING TO CONCERNS REGARDING PROBABILISTIC DECISION MAKING AT THE END OF LIFE

As part of our argument, we note that a Muslim physician need only satisfy the standard of dominant probability, *ghalabat al-ẓann*, in prognosticating whether or not therapeutics would restore *mukallaf* potential and thereby deduce her moral obligations related to treatment. A couple of commentators found this standard for certainty problematic (Al-Khafaji et al. 2015; Rady and Verheijde 2015). Dr. Al-Khafaji and colleagues (2015) remark, "With increasing medical knowledge, life-sign detection precision, and life-maintenance capabilities, it may become increasingly difficult to fulfill even the lesser standard of *ghalabat al-ẓann*" (24), while Drs. Rady and Verheijde (2015) claim that we "circumvent the difficulty of correctly prognosticating by asserting that 'dominant probability (*ghalabat al-ẓann*), in contrast to certainty without doubt (*yaqīn*), is acceptable' and that "'dominant probability' in futility determination and treatment withdrawal illustrates already pervasive 'therapeutic nihilism' and self-fulfilling prophecies of poor outcome" (Rady and Verheijde 2015, 24) In response we would like to clarify that *ghalabat al-ẓann* represents a probability estimation of greater than 50% but less than 100%, with *ẓann* representing an equal probability that something is true or is false, and *yaqīn* referring to absolute certainty (Qureshi 2014). While Islamic jurists from different schools of law may add further gradations within the category of *ghalabat al-ẓann*, this category "is the standard for evaluating whether a particular (ethical) legal conclusion is authoritative or not" (Emon 2009, 435). Given the proper study design, empirical data do support prognostication within the level of precision demanded by *ghalabat al-ẓann* and the Muslim physician should utilize those data in goals of care assessment. Where evidence is lacking we agree with Dr. Al-Khafaji and colleagues that the Muslim physician must proceed with caution. However we disagree with the suggestion that certainty without doubt (*yaqīn*) is the required level of certitude in end-of-life care decision making. *Yaqīn* demands 100% certainty, a level that nearly the entire corpus of Islamic law does not meet due to ambiguities within scriptural source texts (Emon 2009). Furthermore, in an acknowledgment of the uncertainties related to moral deliberation the Prophet Muhammad requested experts to exert their utmost to arrive at a correct decision, noting that the one who arrives at the right answer is doubly rewarded while the one who surmises incorrectly receives a reward also ("Sahih Muslim Book 18, Hadith 4261" 2014). In response to Dr. Rady and Verheijde's proposal to apply the level of *yaqin*, it is critical to note that in Islamic ethico-legal deliberation the *yaqin* metric is applied through the maxim of *al-yaqīn la yuzul bi-shakk*, certainty is not eroded by doubt. The word *shakk* here refers to a probabilistic determination of 50% certitude and is used interchangeably with *al-ẓann*, and importantly does not refer to dominant probability (Rosenthal 2006). The maxim protects against classifying a change of state (ownership for example) based on incomplete evidence. Relevant to our discussions, this maxim was employed by some Islamic jurists to state that brain death determination was of insufficient certitude for brain death to be equated to death proper within Islamic law (Moosa 2000; Padela and Basser 2012). Yet some jurists permitted the withdrawal of life support upon brain-dead individuals in light of the physicians' probabilistic determinations that brain-dead patients would not have any appreciable neurological recovery even if provided with maximal life support and would die within a short time period (Moosa 2000; Padela, Arozullah, and Moosa 2011). We reiterate that probabilistic determinations are innate to Islamic law and do not disqualify medical science from having epistemic value in the determining a physician's moral duties.

RESPONDING TO CONCERNS ABOUT NOT RESPECTING PATIENT AUTONOMY IN DECISION MAKING

Drs. Rady and Verheijde (2015) believe that the "enforcement of non-*mukallaf* status can violate individual autonomy and permit nonconsensual termination of a person's life because of her severe neurologic disability" (16), while Dr. Ilkilic (2015) worries that clinically applying our ethical rubric would run the risk of "a patient who cannot consent but does not share the basic assumptions [in our approach] to be treated against his or her interest and value system" (22). These concerns are unwarranted. Our article offers an Islamic ethical framework through which a Muslim physician can consider his or her own moral imperatives regarding critical therapeutics at the end-of-life. While we hope that Muslim physicians consider our framework, they may of course choose other frameworks. Furthermore, just because a physician holds a certain opinion regarding goals of treatment or identifies a moral conflict with a certain treatment algorithm, patient autonomy does not necessarily fall by the wayside. If and when a conflict arises between the clinical providers and patient and surrogate decision makers, there are many ways in which to manage value conflicts, including consultation with clinical ethics committees and involving other physicians in clinical care. In our article we work through two cases where there may be conflict between what our rubric judges to be the moral imperative upon the Muslim physician and what the patient or surrogate decision maker desires. In that section we note that even where "a Muslim

physician has no Islamic obligation to continue/initiate such treatment . . . one can choose to perform the action" (9) because it lies in the realm of the permitted. We further note that where a Muslim physician believes that "an Islamic obligation exists to offer medical treatment since it would help the patient recover *mukallaf* potentiality" (9) and the patient/family refuses, that "recusing herself from clinical care" (10) can be an acceptable recourse provided clinical care can be transferred to another clinician. If transferring care is not possible, we note that a physician must abide by legal precedents regarding "the patient's right to refuse life-sustaining measures" (10) because "some Islamic authorities suggest that a Muslim physician is [Islamically] obliged to abide by the 'law of the land' even if she has moral objections to certain medical treatment" (10). Clinical care involves fiduciary responsibilities on the part of the physician and consensual acceptance of therapeutic regimens by the patient; our article upholds these notions.

RESPONDING TO CRITIQUES RELATED TO OUR METHODOLOGY

In this final section we respond to some critiques of our methodology. Drs. Rady and Verheijde (2015) believe that we have "realigned the moral code of Islam with Western secular bioethics." Dr. Emran (2015), on the other hand, feels that our paper suffers from "an overreliance . . . on Islamic jurisprudence in ethical issues" and illustrates that "taking that jurisitic rule as the guidance in all medical cases leads to implausible results such as the one that there is no obligation to seek medical therapy in non-life-threatening cases" (28). Instead, Dr. Emran suggests that Islamic philosophy and Sufism may be better "alternative sources of understanding Islamic ethics" because of their emphasis on the "development of virtues and eradication of vices." Dr. Ilkilic (2015) finds the casuistic method of Islamic law "becoming increasingly problematic when addressing complex contemporary bioethical problems" (22) and considers our suggestion that patients who never had *mukallaf* potential require a different ethical framework for goals of care as illustrative of the problematic piecemeal approach casuistry, and Islamic law, offers. He suggests we need to consider "normative arguments from Islamic anthropology and philosophy" "to govern clinical practice and address complex issues in modern bioethics" (22).

Dr. Al-Khafaji and colleagues (2015) prefer that instead of a Sunni law framework involving considerations of *mukallaf* potential and allowing for physician's to make decisions based on a dominant probability, *ghalabat al-ẓann*, Shiite moral theology and law can be used to define Muslim moral obligations because its cautious approach has value for all clinicians. Accordingly, they privilege Ayatollah Sistani's rulings in outlining that the Muslim physician should continue treatment where withdrawing therapy is not obligated and/or when prolongation of physiological life is not forbidden.

Islamic bioethics represents a field in construction, as its content and scope, as well as its research methodologies, are the subject of considerable ongoing debate. We recognize that in the Islamic intellectual tradition, notions about moral norms, the good, and the ethical are scattered across different sciences, including moral theology (*uṣūl al-fiqh*), scholastic theology (*'ilm al-kalām*), jurisprudence and law (*fiqh*), and the sciences related to moral character development (*taṣawwuf* and *adab*). In this article and other writings we assert that the "Islamic" content of Islamic bioethics must be indexed to the scriptural source-texts of Islam, the Qur'an and Sunnah, and the "ethics" component of Islamic bioethics must acknowledge the primacy of Islamic ethico-legal theory in deriving normative values from the scriptural source texts. The reasons for beginning conversations about Islamic bioethics by looking at Islamic law are that Islamic law has both ethical and legal content, it addresses issues of normativity, it provides a methodology by which to consider ethical obligations and weigh scriptural evidence, and it is frequently looked to by both patients and physicians when faced with ethical dilemmas in modern medicine. We caution against ignoring Islamic ethico-legal methodology when deriving Islamic bioethical perspectives because of the danger of developing an idiosyncratic approach to moral deliberation and because conceptual errors may result from noncomprehensive readings of the scriptural source texts.

That said, we have called for robust multidisciplinary engagement that can help develop a comprehensive Islamic bioethical theory (Padela 2013; Padela and Basser 2012; Padela et al. 2014). Such a theory would reassess ethicolegal constructs based on premodern understandings about the world in light of newer scientific data, address epistemological questions regarding how social scientific data provides us insight into the normative, and allow for the production of Islamic bioethics primers that can service the needs of Muslim religious leaders, patients, and healthcare providers.

In response to Dr. Emran's (2015) concern that about the "implausible results . . . [that] there is no obligation to seek medical therapy in non-life threatening cases" it is true that the dominant position within the Ḥanafī and Mālikī school of law is that medical treatment is permissible and not obligatory (Ghaly 2010). What seems like an overreliance on "juristic rules" to arrive at the aforementioned position was actually founded on a theological concern. Islamic jurists were aware of authentic and established reports that demonstrated that the Prophet Muhammad and his closest companions at times forwent medical therapies and instead chose to place their trust in God for cure. They were also aware of authentic Prophetic statements that suggested that individuals who did not rely on medical therapy would be among the foremost who enter paradise ("Sahih Al-Bukhari—Vol. 7, Book 71, Hadith 648" 2014), and that illness and cure were from God. In light of these scriptural evidences and historical incidents that indicated that relying on God to cure was a normative response to human illness, many Islamic jurists

did not find sufficient grounds to mandate seeking medical care because such a ruling would appear to discount the possibility of God's curing without a 'medical' intermediary and suggest that the Prophet's and his closest companions' deeds were not consistent with Islamic ethico-legal norms. Consequently, one must recognize that theological concerns are part and parcel of Islamic ethico-legal deliberation. Indeed, after the minimal ethical obligations are derived from law (which also accounts for theology) one can move beyond "what can I do" to "what should I do," and we agree with Dr. Emran that the Islamic genres that correlate with the sciences of virtue ethics, *taṣawwuf* and *adab* and others, have much to offer in that "should I" realm.

We concur with Dr. Ilkilic that Islamic anthropology and philosophy may guide Islamic jurists and bioethicists toward a broader understanding of the human person and of the meanings associated with life and death. Our concern remains deciphering normativity in these disciplines. Islamic moral theology offers established parameters for distinguishing normative judgments from nonnormative ones and a method of prioritizing among different evidences from scripture. Lived experiences provide insight into the meaning-making activities of Muslims, and philosophy can help provide a *telos* to the practice of medicine; however, by themselves lived experiences and philosophy cannot tells us what God requires of us. This latter question requires investigating scriptural source-texts and utilizing the *uṣūl al-fiqh* methodologies.

In response to Dr. Al-Khafaji and colleagues, we greatly appreciate their elaboration of how our rubric would be received in Shīʿī circles. There are clear areas of dissonance between our proposed framework and the views of the authorities Dr. Al-Khafaji and colleagues quote. In our article, and here again, we reiterate that we utilize Sunni moral theology to derive a theological rubric to guide moral imperatives in end-of-life care from the clinician's vantage point. In our article we noted that Shīʿī authorities such as Ayatollah Sistani state that once treatment has started, physiological life in and of itself must be saved, and life-support systems should never be withdrawn. The rationale underlying this view, as explained by Imam al-Qazwini at our 2011 Islamic bioethics conference, is that medical science cannot provide a window into metaphysical realities. Therefore, the living human even without any appreciable neurological status may still be in communication with His Lord and Shīʿī Muslim physicians must maintain physiological markers of life as far as possible ("Where Religion, Bioethics, and Policy Meet: An Interdisciplinary Conference on Islamic Bioethics and End-of-Life Care" 2011). It must be noted, however, that Shīʿī authorities are not all one voice and that there are notions within Shīʿī moral theology and law that are in line with Sunni views. Some Shīʿī authorities note that the presence of "human intellect in the patient [is] the determinant for continuation of life prolonging treatments" and "the irreversible cessation of human voluntary acts" is one criterion for establishing death (Mobasher et al. 2014, 4). These views appear to cohere with *mukallaf* potential as a goal of care.

Finally, Drs. Rady and Verheijde (2015) are greatly concerned that we have realigned "the moral code of Islam with Western secular bioethics" (16). Curiously, some commentators consider us too "deep" in Islamic law and others believe us to be too "steeped" in Western bioethical principles. We would like to point out that being "Islamic" does not necessitate being at odds with "Western" bioethical principles and that judging whether a moral argument is sourced within Islam requires assessing whether the ethico-legal argument follows the established techniques and source methodologies of Islamic moral theology and law. The Islamic tradition is vast and plural but also has accepted conventions of moral reasoning and argumentation, and jurists are experts of this discipline. There were several conceptual errors in some critiques, perhaps due to a misunderstanding of Islamic ethico-legal constructs and/or established exegetical methodologies and hermeneutical theories. For example, the conflation of the practice of remembrance of God with the Arabic root *z-k-r*, or glorification of God with the Arabic root *s-b-h*, with the specific usage of the Arabic root word *a-b-d* as a way to refer to ritual worship was an exegetical and hermeneutics-related error. While we do not have mastery within Islamic moral theology and ethico-legal methodologies, we work closely with Islamic jurists to develop arguments in accordance with established practices and norms of the Islamic ethico-legal sciences.

We believe that the lack of a cross-disciplinary dialogue among biomedical scientists and Islamic jurists hamstrings the field of Islamic bioethics such that the Islamic bioethics-related writing of jurists often does not address the realities of modern medicine and the Islamic bioethics-related outputs of health care providers often fail to accurately portray Islamic ethico-legal constructs and law (Padela, Arozullah, and Moosa 2011; Padela, Shanawani, and Arozullah 2011; Shanawani and Khalil 2008). For this reason, we consider multidisciplinary collaboration and the generation of a shared conceptual vocabulary related to bioethics as a critical first step in offering Islamic perspectives to the ethical challenges related to biomedicine. We look forward to being in dialogue with the commentators and readers of our articles, and continuing to work with traditional Islamic jurists, Islamic studies experts, social scientists, and other stakeholders to move the field of Islamic bioethics forward. ■

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