

ETHICS OF CRITICALLY ILL PATIENTS — AN ISLAMIC VIEWPOINT*

By Dr. Faroque Khan, M.B., F.C.C.P., F.A.C.P., F.R.C.P.(C)
Chief, Division of Pulmonary Medicine
Queens Hospital Center
Associate Professor of Medicine
SUNY, Stony Brook, NY

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Life and death choices have always been a part of the human condition. Years ago, most people died at home. But today more than 80 percent of patients in the USA, die in hospitals or other institutions. In such institutions the techniques of intensive care can prolong life for hours, days or, in rare cases, even months or years. Even the definition of death has taken a new dimension because of newer advanced techniques and equipments. The generally accepted definition today rests on the state of the brain and its ability to continue the complex orchestration of organ functions and chemical balance, which constitute the essential component of life.

The new ability to postpone death has raised issues which are exceptionally difficult for lay people and professionals alike. The vital distinctions between natural death, euthanasia and suicide has become blurred. Sometimes patients prefer to end the heroics of modern medicine, and the pain that goes with it. This complex subject in which few generalizations are possible, has been the subject of intense discussion in medical and non-medical literature¹⁻⁴. There is a scarcity of guidelines regarding the Islamic concepts of this extremely complex subject. In the following discussion I will attempt to focus on a few aspects of this subject, particularly with reference to:

- a. Definition of death both from a scientific and religious view point.
- b. The benefits and limitations of intensive care.
- c. Withholding of life support systems, from the critically ill patients.

Definition of Death:

The definition of death has been debated in scientific literature. While the old classic definition of cessation of cardiac and respiratory function is still

valid in instances where death occurs in an environment where life support systems are not available (home), it is quite a different story if death occurs in an institution. Most Americans can expect to go through the tortures of the damned before they are allowed to die of cancer, heart or lung failure or pure senile decay.⁵ Several authors have suggested that brain death, defined as occurring in an individual who has sustained a) irreversible cessation of circulatory and respiratory function, b) irreversible cessation of all functions of the entire brain, including brain stem and the determination of death must be made in accordance with accepted medical standards⁶⁻⁹. This definition has been legally accepted in about 30 out of a total of 50 states of the USA. There are those who disagree with the concept of brain death on moral^{10, 12} and scientific grounds¹². Thus there is no uniformity for defining death from a scientific viewpoint.

Religious Definition:

The sanctity of life and the inevitable occurrence of death for all of mankind has been stressed in Islam.

Quran 3:185 - Every soul will taste of death.

Quran 39:30 - Truly thou wilt die (one day), and truly they (too) will die (one day).

Quran: 3:145 - Nor can a soul die except by God's leave, the term being fixed as by writing.

Quran: 39:42 - Allah takes away the souls upon their death; and of those who do not die during their sleep. Those on whom He has passed the decree of death He keeps with Him and the rest He restores for a term ordained. Verily in this are signs for those who reflect.

Future correspondence to:

Dr. F. Khan
Division of Pulmonary Medicine
Queens Hospital Center
82-68 164th Street
Jamaica, NY 11432

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Quran: 63:11 - And Allah reprieves no soul when its term comes.

While the inevitability of death is made fairly clear in the above verses, the exact definition of death remains vague.

Just as the inevitable occurrence of death is well defined, the sanctity of human life has also been abundantly stressed in Islam.

Quran 2:195 - And do not with your own hands cast yourselves into destruction...

Quran 4:29 - Nor kill (or destroy) yourselves: For verily God hath been to you most merciful.

Quran 17:31 - And slay not your children for fear of want. We shall provide for them and for you. Lo! Their slaying is a great sin.

Quran 5:35 - Whosoever killeth a human being for other than manslaughter or corruption in the earth, it shall be as if he had killed all mankind, and who so saveth the life of one, it shall be as if he had saved the life of all mankind.

Muslims are even permitted the use of forbidden things if, such use is deemed necessary for preservation of life.

Quran 6:145 - Say: "I find nothing in what has been revealed to me that forbids people to eat any food except carrion, running blood, and swine flesh for these are unclean - and any flesh that has been profanely consecrated to deities other than Allah, but whoso is compelled to eat any of these, neither intending to sin, nor to transgress, will find Allah forgiving and merciful."

Thus Islam advocates that every effort should be made to preserve life, take good care of the body and at a predetermined time, death will occur and spare no one.

The technological and scientific advances during the past thirty years have had a profound beneficial effect on the health care of people all over the world. Thus small pox vaccination, poliomyelitis vaccines, antibiotics, pacemakers, renal transplantation, corneal transplantation and many other similar advances have provided relief from suffering to millions of individuals. The technological advances have also created dilemmas from ethical, economic and scientific viewpoints, such problems usually come into sharp focus in those critically ill patients, whose survival depends on the continuation of the life support system.

Benefits and Limitations of Intensive Care:

The Intensive Care Units have made a significant impact in the survival of critically ill patients. In the Respiratory Intensive Care Unit at Queens Hospital Center which I supervise, we documented an initial mortality of 33% and as the expertise and the know how improved, the mortality plateaued at 17-20%, a

level which has remained constant after treating over two thousand critically ill respiratory failure patients during the past thirteen years^{13, 14}. Similar results have been reported by several other centers dealing with various types of critical care units¹⁵.

While the benefits are obvious there have been numerous occasions when serious ethical issues were raised during the course of treating various patients.

Example: R.B. is a 60 year old female who was hospitalized in November, 1980 after suffering a respiratory burn in a fire. She was intubated, resuscitated but suffered an irreversible hypoxic brain damage. Three years later, after an estimated hospital bill of approximately three hundred twenty seven thousand dollars, she is still in the hospital in a deeply comatose state with complete absence of all higher functions such as speech, voluntary movements, emotional reactions and memory. She has intact brain stem functions with spontaneous respiration, pupillary, corneal, spinal reflexes and has a normal thermoregulations and electrolyte water balance. She suffers from the Apallic syndrome¹⁶. Though legally "alive" she represents an example of an unfortunate outcome of critical care and acute resuscitation. Karen Ann Quinlan who's respirator was discontinued, at the request of her parents after the approval of the proper legal authorities, has been in a similar state for the past six years.

Economic Considerations:

Is it justifiable to continue life support system in hopelessly sick patients, at a prohibitive cost to the family and society? I have been approached by several family members requesting life support system termination, when it became obvious that the chances of the patients' recovery were negligible. One of the concerns expressed by such family members, was the anticipated burden of a large hospital bill. In studying the cost of intensive care at a referral cancer center in NYC, the average daily cost was 1,500 to 2,000 dollars daily¹⁷. In another study a five year old child was hospitalized for two months in a critical care unit following an automobile accident. He made a slow but uneventful recovery and left the hospital 14 months later, with a total hospital bill of \$260,000, not counting the physicians' fee¹⁸. Was this justified? The 1979 cost of dialysis for renal failure in the USA was 1 billion dollars while the estimated cost in 1985 is 2.5 billion dollars¹⁹. Can society afford this? Now let's consider the status of health care in underdeveloped countries of the world.

In poor third world countries, life expectancy at birth averages only 51 years, and in several it is less than 45 years. Mortality rates are 10 to 20 times higher for infants and for children ages one to four than in developed countries. Nearly half of all deaths

occur in children under five years of age. In these countries the percent of population with access to safe water ranges from 25 to 58 percent. The major causes of death are preventable diseases like diarrheal diseases, respiratory infections, tetanus and childhood infectious diseases such as diphtheria, measles, and whooping cough. With an annual estimated total public expenditure of \$5 (five) per capita per year, it would be possible to provide primary health care to all individuals in the developing world²⁰. Thus the obvious dilemma of providing expensive care for the privileged ones in the western world while denying basic amenities to the poor in the developing world.

Thus, from this brief discussion, it's obvious that while intensive care is helpful and useful in the majority of patients, if some guidelines are not followed, these ICU's can become the source of anxiety, grief and suffering both from a scientific and economic point of view. The dilemmas presented above are not the exclusive domain of ICU's. Most busy physicians face daily ethical decisions, examples:

1. Seventy year old man, previously healthy, develops a metastatic osteosarcoma of right hand, after several amputations failed, patient refused to permit disarticulation of shoulder. Should the physician pursue with the treatment or respect the wishes of the patient²¹?

2. Thirty-five year old automobile accident patient is determined to be brain dead. His wife refuses permission to discontinue respirator and wishes to take him home and care for him.²¹ Should physician abide by the wife's request?

3. Twenty-four year old woman, 23 weeks pregnant, develops brain death after status epilepticus. Physicians continue life support system for three weeks and deliver a 26 week live baby after bedside Caesarean section. Thereafter the life support system was discontinued and the mother died²². If brain death is equivalent to 'real' death, then how could a dead person give birth to a living child?

4. An 83 year old patient aphasic, bedridden, in a nursing home for three years, following a stroke develops a fever and possible pneumonia. Should she be treated or allowed to die²³.

5. A patient over 50 develops a second relapse of acute myelomonocytic leukemia, which has a less than 10% chance of recovery. Should this patient be intensively treated in an acute care unit²⁴?

Many other examples of similar situations, with no easy answers could be presented.

What are the Legal Guidelines for such Questions?

There is no uniformity in the legal opinion regarding such questions - examples:

a. Quinlan Case - This young female was in a deep

coma following a probable drug overdose. She was on a life support system (respirator). Her parents requested the removal of the respirator. The physicians refused to do so, and in a much publicized trial the New Jersey Supreme Court upheld the patient's constitutional right of privacy including the right to refuse treatment where such treatment perpetuates comatose, vegetative existence. This may be exercised on incompetent patients' behalf by guardian, family or physician after the approval by ethics committee²⁵, ²⁶. The respirator was removed, Karen Ann Quinlan continues to remain in a vegetative state in a nursing home, six years later.

b. Saikewicz Case - This case involved a 67 year old mentally retarded male. He could not talk but communicated with gestures and physical contact. He was physically strong, ambulatory and was in state schools all his life. He developed acute myeloblastic monocytic leukemia. The recommended treatment was blood transfusion and chemotherapy. His two sisters refused to get involved. The court appointed guardian recommended no treatment. The judge dissented and ruled that life support and other issues are to be decided by courts and mental retardation plays no role in life saving. This decision generated a large debate in the medical journals²⁷, ²⁸.

c. Dinnerstein Case - This case involved a do not resuscitate order in a 67 year old female who had progressive mental degeneration, Alzheimers disease, with a life expectancy of less than one year. The courts referred the case back to the family and the physician for decision²⁶.

d. Baby Jane Doe - This case involved an infant who was born with Spina Bifida and several other defects including mental retardation. The dilemma confronted by the parents and physicians was whether the surgeons should intervene to prolong life of this severely deformed infant? Without surgery this infant was exposed to the risk of infections and possible death within two years. With the surgery the infant might live into her twenties, but would remain retarded, bedridden and doomed to constant pain. The infant's parents and the doctors agreed not to operate but a "right to life" advocate who had heard of the case objected and appealed to the courts for permission to have the infant operated. This case generated extensive newspaper and TV coverage and after the appeals court agreed with the families decision, the U.S. Justice Department sought an unprecedented suit seeking the hospital records of this infant Baby Jane Doe. The controversy remains unresolved²⁹, ³⁰.

I have presented Quinlan, Saikewicz, Dinnerstein and Baby Jane Doe cases to demonstrate the diverse legal opinions which have been handed down by courts, when confronted with ethical issues involving

intensive care. Prudence dictates that until legislation is enacted to dispel the ambiguities that now exist, physicians should be guided by their respective hospital policies. To the extent that hospital policies incorporate committee review procedures, the physician should take full advantage of them.

Religious Guidelines:

Q45 V 26: Say: "It is God who gives you life, then gives you death, then He will gather you together for the day of judgement about which there is no doubt: but most men do not understand."

There are occasions when critically ill patients do not fulfill the classic criteria of death 1) Cessation of heart beat, respiration. Such patients can be sustained with artificial support systems for prolonged periods of time. In such patients the obvious questions is 1) Does intensive care prolong life or, 2) Does intensive care prolong death? If one accepts brain death as real death then terminating life support system from such patients presents no problem³¹. But in many states of the USA, brain death is NOT accepted as death and a physician terminating life support system, in such a patient could be charged for murder³². In the presence of these conflicting views, what does Islam advise us? Islamic Jurisprudence i.e., FIQH is itself based on 1) The Quran, 2) The Hadith, 3) The IJMA and, 4) The Qiyas.

There are no specific guidelines, that I could find, regarding these issues in the Quran or the Hadith, nor would one expect to find such answers. However, the permission for Qiyas and IJMA allows us, Muslims, to think, debate, rationalize and come up with answers to the changing problems. The authenticity of Qiyas as a basis of FIQH the following celebrated incident of the life of Prophet Muhammed (Pbuh) can be quoted.

Maadh - ibn-i-Jabal (r.a), The Governor designate for YEMEN paid a visit to Prophet to take his leave before departure. The following conversation took place:

Prophet - On what basis shalt thou decide and judge cases?

Maadh - According to the Book of God (Quran).

Prophet - And if thou dost not find any provision therein?

Maadh - Then according to the Conduct of the Messenger of God (Prophet Muhammad Pbuh).

Prophet - And if thou dost not find provision therein?

Maadh - Well, then, I shall make every effort with my own opinion.

The prophet was so delighted at this reply that he exclaimed "Praise be to God who hath guided the envoy of His envoy to what pleaseth the envoy of God." Other instances demonstrating the validity of

Qiyas and IJMA as a basis of FIQH are available³³. This individual effort of opinion and common sense on the part of an honest and conscientious man is not only a means of developing law, but also received the benediction of the Prophet (Pbuh).

I believe this incident from the life of our Prophet (Pbuh) is as relevant today, as it was 1400 years ago. *In the absence of guidelines, a common sense approach with a consensus of opinion should provide the guidelines for starting, changing, adding or stopping life support system in critically ill patients.* This type of an approach is already in use in several large medical centers in the USA. Patients admitted to Critical Care Unit are assessed regularly and classified according to the following:

Class A: Maximum therapeutic effort with no reservation.

Class B: Maximum therapeutic effort but daily reassessment.

Class C: Selective limitation of therapeutic measures - e.g., do not resuscitate orders, arrhythmias not treated, vasopressors not used for hypotension, ventilators not started.

Class D: All therapy can be discontinued.

If any of the staff members disagree with the classification, then the cases are referred to a special committee. Out of a series of 209 admissions this was necessary in only 15 admissions³⁴.

Conclusions:

In this article, I have attempted to focus on some of the contemporary ethical issues which face physicians and patients alike, particularly in the Western world. These issues have assumed great relevance due to the rapidly enlarging field of technology, which permits the continuation of vital body functions, sometimes for indefinite periods of time. Islam stresses the value and sanctity of life, while the inevitability of death and respect for the dead is also emphasized. We, as physicians, are urged to make every effort to relieve suffering, however, due respect for the dead is urged and violation of the dead, is unacceptable in Islam. There are occasions when distinctions between the dead and the living are not clear, and I tried to convey that message in this article. In such instances, when doubts and confusion prevail, the use of IJMA and Qiyas, allow us as physicians, to make intelligent choices in dealing with such critically ill patients. I would hope, that other interested physicians and scholars would give this matter some thought and express their opinions in future publications of JIMA. After all, that would constitute an IJMA for developing Islamic guidelines in dealing with ethical issues related to life and death.

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