A Matter of Life and Death

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The Ethics of Resource Distribution, Intensive Care and Treatment Choices in the Light of the COVID-19 Pandemic BBSIG-06 | 25 April 2020

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Executive Summary

1. The COVID-19 pandemic is placing extreme pressure on the NHS, including healthcare professionals who have to take critical decisions at an unprecedented rate and manner.

2. It has led to scarcity of health resources that may necessitate difficult decisions about who receives what clinical support, which must consider the needs of the population as a whole, not merely the individual.

3. Decisions made at the bedside to allocate or withhold/withdraw intensive support to patients are traumatic and difficult for all concerned – patients, families and professionals – and need to be justified with clear and transparent clinical processes.

4. Questions of clinical benefit form the primary decision-making guidance as to who should receive what types of clinical support, and this is determined by clinical algorithms used by front-line clinicians, which relate to age, frailty and the presence of other serious illnesses.

5. It is acknowledged that the likelihood of recovery from ICU care for COVID-19 patients is equivocal at best and unlikely in vulnerable populations, and this impacts on decisions about whether or not intensive care should be provided in the first place.

6. Islamic bioethics acknowledges the autonomy of individuals or families to choose to abstain from intensive support and miss out on possible benefit in order to facilitate other human goods, such as a peaceful death.

7. It also acknowledges – whilst
affirming the theological proposition that the only true Cause is God – the right and duty of clinicians to act in light of empirical evidence in making such decisions.

8. It is permissible for clinicians to withhold or withdraw life-sustaining support if the clinical case is that the harms clearly outweigh the benefits, and for policy makers to instruct the same.

9. Preference for life-saving care on the basis of ‘social worth’ or utility – though not currently proposed in UK guidance – is at odds with Islamic bio-ethics and must be avoided, with the only possible exception being those with rare, irreplaceable skills that might directly contribute to societal welfare during the COVID-19 pandemic.

10. Muslim individuals and families are exhorted to follow the illuminated Prophetic practice and prepare for death emotionally, spiritually and practically – especially by drawing up their wills and advance directives relating to what level of support or care they would desire under such circumstances.

11. We exhort all people to turn to their Lord in sincere supplication, to rectify their affair with Him, and pray for deliverance and salvation on behalf of all those undergoing any form of hardship or difficulty anywhere in His creation.
1. Introduction

The British Board of Scholars & Imam (BBSI) is an apolitical national assembly of imams, traditional scholars and Islamically-literate Muslim academics formed to facilitate scholarly intra-Muslim research and dialogue. Our aim is to provide authoritative ethico-theological guidance and leadership on matters relevant to Muslims, whilst promoting wider community welfare. It primarily seeks to do this by developing theological leadership that can authentically represent the rich scholarly inheritance of Islam, whilst responding flexibly to the context of modern times.

Its ultimate aim is to both serve and represent the Muslim community in an ethical, inclusive, professional and scholar-led way. The BBSI especially takes seriously the responsibility to provide theologically-grounded, practically-focussed, holistic and – above all – cool-headed and far-sighted guidance to the community in times of generalised anxiety and panic.

This guidance will lay out an ethical framework, sourced from the Islamic tradition, which can guide Muslim stakeholders in their decision-making regarding resource allocation and end-of-life care. It will address patient/family-level, clinician-level, and policy-maker level considerations, while recognising that every decision should be contextual and multi-faceted.
2. The Need for this Guidance

It has become evident that the world is experiencing the greatest shared crisis in living memory with the COVID-19 pandemic. The catastrophic effects on already fragile, desperately poor and war-torn areas of the world, where it has added even further unwanted stress to infrastructures, are terrifying and incalculable. For them, we can only extend our hands in prayer to Almighty God to grant relief and mercy to their populaces, and raise our voices to our government and the citizens of this land – reminding them and ourselves to turn their thoughts and care also to those beyond our borders, who are enduring the same crisis with far less resources than we have. For times of distress are times of remembrance of our shared humanity, beyond borders, ethnicity or culture, and to manifest the noblest qualities of the human condition: compassion, kindness, love, concern and generosity.

Although our focus of concern is humanity in general, however, our area of influence is our own country, which is experiencing unprecedented emergency conditions. The NHS, in particular, is effectively on a war footing: attempting to both marshal and keep safe a workforce that is placing itself in harm’s way to care for others, absorb large numbers of seriously ill patients, and husband increasingly scarce resources. Every day, there are difficult decisions being made by doctors, nurses and trusts that might well mean life or death for those on the receiving end.

Various public health measures such as social distancing, lockdown orders, and the shutting of non-essential business, have been employed globally to “flatten the curve.” By reducing the rapid spread of the Covid-19 virus, it is hoped that healthcare resources will not be stretched beyond their capacity, and lives will thus be saved. Although we all hope that this preventative approach is able to stem the contagion – and thus preserve limited healthcare resources – policy makers, bioethicists, clinicians and religious leaders have been considering options if these measures fail and some system of rationing of limited resources needs to be put in place. At the same time, conversations
about the ethics of end-of-life healthcare within families have taken on greater significance given the reality that the death toll from Covid-19 continues to rise.

Against this backdrop, this position paper will lay out an ethical framework, sourced from the Islamic tradition, which can guide Muslim stakeholders in their decision-making regarding resource allocation and end-of-life care. It will address patient/family-level, clinician-level, and policy-maker level considerations, while recognizing that every decision should be contextual and multi-faceted.

It will also address the fact that, in the NHS, policy is likely to be set at central government or trust level, with clinicians generally expected to adhere to protocols of care rather than make individual clinical decisions. This is because the healthcare system is a web of dependencies, with a decision at one point having ramifications at other points of the system that the clinician may be unaware of. A simple example of this might be a doctor in A&E deciding that her patient should have ventilatory support, completely unaware that another doctor on the ward has identified another patient who might be even more in need of it.

2.1 The Ethical Dilemma of the COVID-19 Pandemic

Before delving into an Islamic bioethical analysis, it is critical to appropriately lay out the current context to which the tools of the tradition will be applied. A well-known maxim of Islamic law is that an ethico-legal judgment can only be made after conceptualising the situation properly (ḥukm al-shay far’ ‘an taşawwurihi). Thus let us briefly sketch out the context.

Questions of what treatment to offer, and to whom, are a central concern of medical ethics, and decisions like these are commonplace in clinical practice. Generally, they turn on the concepts of:
• **Utility** (will the benefit of a particular treatment measurably outweigh the potential harm to the patient, in which case it should be initiated and/or continued), and

• **Futility** (when is the treatment unlikely to bring about benefit or cause more harm than good, in which case it should not be initiated or be withdrawn)

The clinical judgment about utility and futility is an often complex and highly individual decision, usually taken by experienced specialists; yet in the current pandemic, as noted, it may out of necessity be devolved to less experienced clinicians to determine on the basis of protocols. The deeper philosophical questions about how exactly benefit and harm are measured – whether purely clinical or considering other aspects of life quality or human worth – will not be explored here to save time, but are extremely important and will be touched on later. For example, is a peaceful death surrounded by family and prayers better than enduring invasive and intensive CPR treatments that might save one’s life?

There are, however, two unique aspects of our current crisis that have prompted much soul-searching among clinicians and ethicists:

1. **Unfamiliarity:** COVID-19 is a novel condition, meaning that little is known for certain about its mechanisms of action, what treatments work, how they should be given and to whom. This makes the benefit/harm analysis a moving target, leading to differences of opinion, changes in guidance, recognition of past errors, and much confusion and dismay amongst the populace.

2. **Resource Scarcity:** the very volume and frequency at which these potentially life-saving are required entails the concern that there will simply not be enough of the life-saving treatments to cater for everyone. This in turn may necessitate some form of selection of patients being carried out, where some receive higher levels of support than others. How precisely this selection should be performed is the key question, but
it revolves around the four key principles of biomedical ethics: respecting patient **autonomy**, avoiding harm (**non-maleficence**), procuring benefit (**beneficence**) and ensuring **equity**. Such decisions also can be the cause of much mental distress to patients, family and healthcare professionals (including, potentially, just-qualified doctors and nurses) who are completely unused to such weighty decisions.

That this concern for scarcity is credible is predicted by multiple epidemiological models based on real-world data on Covid-19 and similar diseases. The healthcare resources that will be scarce supply if the current infectivity rates hold true include ventilators and dialysis machines, the associated intensive care/treatment beds, respiratory technicians/therapists, and especially critical care nurses and other clinicians needed to manage patients on ventilators.

Additionally, given that Covid-19 spreads via respiratory droplet transmission, there is concern that the personal protective equipment (PPE), needed by personnel to treat such patients, may also run out. From the perspective of clinical staff, the scarcity of PPE is a major source of angst: if providers lack adequate PPE, they are at high-risk of becoming afflicted with the disease themselves, and thus spreading it to both other vulnerable patients and their own families. At the same time, if too many healthcare workers become sick or unable to work, there may not be enough clinicians and support staff to treat patients, thus creating a feedback loop that exacerbates scarcity of healthcare resources.
3. Paradigms of Ethical Decision-Making

To address the dilemma of such ethical decisions in the context of the scarcity of resources, thinkers and policy-makers are drawing upon previously established protocols related to disaster relief, triage, and pandemics. These frameworks and policies may be rolled out at the governmental or hospital level, and are of various sorts. As these frameworks try to balance considerations of social justice, public benefit, and clinical utility in the allocation of scarce resources, several common features stand out.

1. **Clinical decision tools** are employed to determine whether a particular patient should receive a higher level of intervention (such as intubation and ventilator, along with associated resources and life-sustaining measures). These are evidence-based algorithms used to judge which patients are most likely to clinically benefit from the intervention, measured in terms of likelihood of survival, prolongation of life, etc. For example, a young fit person is more likely than an elderly frail person both to survive the ordeal of ventilation and enjoy a long life thereafter.

2. Secondly, they attempt – as far as possible – to **shield front-line clinicians** from moral decision-making at the bedside during a time of crisis. By standardising protocols at the institutional level as much as possible, the arduous duty of deciding resource allocation for that patient is removed to those less likely to be emotionally affected by the consequence of doing so.

3. Finally, and more controversially, where the risk/benefit calculus for two patients is roughly equal, the frameworks consider if **other non-clinical parameters** may be ethically utilized to pick one over another. In some countries – though crucially, **not the UK at present** – social utility might be considered – looking at the instrumental value of an individual to society. Similarly, some have advocated for citizens of a
nation to be prioritised over “illegal” immigrants or refugees, based on the assumption that the former have paid into the healthcare system, so should preferentially benefit from its resources. There are many different notions in this category but they all involve value judgements about classes of individuals.

In addition to the above, several features of the contemporary clinical ethics context need to be highlighted.

- First, dominant clinical ethics teaching considers the withdrawal of life support and the withholding of life support to be morally equivalent – though it should be acknowledged that psychologically for families and staff they feel very different.

- Secondly, especially in crisis resource management situations, the consent of families and individuals to the withdrawing or withholding of life-sustaining measures that are scarce, is considered optional and recommended, but not necessary.

- Thirdly, acting in consideration of the benefit that a future patient may receive from a scarce resource is possible, even if that future patient has not yet presented.

- Options such as a time-limited trial of ventilator support before a protocol automatically withdraws can be considered moral. Similarly, withdrawing life support from a patient in the emergency room who stands to benefit the least from such support in order to preserve having a ventilator for a future patient can be ethical.

- Claims of conscience related to end-of-life care decision-making are considered legitimate. Generally speaking, healthcare workers can refuse to participate in the withholding or withdrawing of life-sustaining measures should their held values dictate otherwise, in such cases they can defer the objectionable act to other members of the clinical team with the appropriate skill-sets. However, we recognise that this may be particularly difficult to do during the acute and pressurized circumstances of the pandemic.
3.1 How Are Ethical Decisions Made in Practice?

It is important to understand how these theoretical ethical principles are being put into practice currently in the NHS during the COVID-19 pandemic. This information is drawn from the official clinical guidance and policy papers from the Department of Health, the British Medical Association, the experience of frontline clinicians, and others. It is also important to note that, at the time of publishing this guidance, the ICU capacity of the UK appears to be holding up – there are (just about) more beds and ventilators than patients in ICU.

1. The key decision-making tool is that of utility and futility – in other words, the clinical benefit of Advanced Respiratory Support (ARS) to the individual patient. If a patient is deemed unlikely to benefit from ARS, they will be offered other forms of support as appropriate to their circumstance.

- Although this was being determined via a variety of clinical decision tools, the Department of Health has recently issued clear guidance to be applied across the NHS. This ‘scores’ the patient’s likelihood of benefit in terms of three parameters: age, general frailty (what they can and cannot do themselves) and co-morbidities (other serious illnesses). The score then determines whether one would benefit from ARS or not.

- The NHS explicitly prohibits any form of direct discrimination on any basis – race, gender, age, etc – but recognises that, given the decision-making tool, a person may be denied the opportunity for ARS because of age, a pre-existing health condition, etc.

- It is important to note that a patient is scored at the point of admission to hospital, often without any family support, on the basis of their medical history. The question of frailty, however, can of course be influenced by the patient’s self-report. Patients from BAME communities, especially the first generation Muslims, may be unable to adequately express themselves to the admitting
clinician. This should be borne in mind, and families, for example, should write down and send with their relative information about their level of independence for the clinician to review.

- It should also be noted that the scoring system might entail a patient being denied ARS even if beds are available. That is to say, this is not about picking and choosing, but about whether or not a person would ultimately benefit from the intervention. This was also the case before the COVID-19 pandemic, though the process has been streamlined through protocols.

- If the clinician feels uncomfortable or uncertain about the decision that the clinical tool is indicating, they should contact their supervisors or the ICU team to come and perform a second opinion assessment of the patient. Families are also asked to be patient – staff are working under extreme pressure both physically and mentally, and are doing their best to help people and take decisions under the most trying circumstances.

2. Should the clinical benefit be roughly equal, and in the hypothetical circumstance that resources be restricted, either a ‘first-in, first-out’ or lottery system will be applied as the fairest means of selection. The only additional consideration that may be countenanced is that of those with rare or irreplaceable skills that contribute to the survival of others or maintenance of essential infrastructure.

3. It is important to be reassured that – as clearly laid out in the British Medical Association guidance and others – any direct discrimination is strictly prohibited: a person cannot be selected on the basis of race, social class, etc. However, we are not at the point where this sort of non-clinical selection is likely to become common-place, and – if it were the case – it is assumed that such decisions would be made by an ethics committee.
4. Different trusts may institute protocols around time-limited ‘trial of ARS’, in which a patient is afforded the intensive support for a defined period of time before they are reassessed to see if it is likely to help them or not.

5. It should also be noted that there are clinical and ethical safety nets available to both clinicians and patients/families. In addition to the protocols noted above, if a decision is disputed, a second opinion can be sought and, failing that, the decision can be urgently referred to ethics committees which are in operation at present.

As can be seen from the above, in a highly-centralised, socialised healthcare system such as NHS, there is no automatic selection that can be made on the basis of demographics such as race, ethnicity and class; rich and poor alike receive as close to equitable treatment as is possible. There have also been no directives about de-prioritising immigrants, refugees or asylum seekers, and even were there to be, it would be extremely unlikely that it would be applied in practice. This is something to be profoundly grateful for, given the massive levels of health inequality that exist elsewhere in the world. As far as possible, the NHS attempts to fulfil the moral truth that – when it comes to preservation of life and health – all humans are of equal worth.

Nonetheless, it should be noted that indirect discrimination remains a real possibility: by virtue of the clinical protocols, the elderly are less likely to receive ARS; it is also well-recognised that general health, education and poverty are linked. Poverty and social status are linked to frailty and co-morbidities, which can both worsen one's outcome and lead to ‘scoring down’ on the protocols.
4. Islamic Bio-Ethical Considerations

It is beyond the scope of this piece to detail the sophisticated process of Islamic ethico-legal deliberation from revelatory source-texts through rational arguments. It is also beyond the scope to describe the different approaches the various Islamic theological and legal schools take to questions of morality and moral decision-making. For our purposes, it suffices to say that an Islamic bioethical position must take into account:

- Theological constructs related to understanding causality, illness and healing
- Formal conventions related to deriving ethical norms from revelatory sources
- Legal precedents – both in terms of how *ijtihad* (legal decision-making) is performed and how previous *ijtihad* relates to the current context.
- Established juridical constructs and practical tools, relating to general axioms of law and its purposes

4.1 The Theology of Hardship and Awaiting Death

At the outset, it is worth recalling that, whilst taking due practical steps, the believer considers the greater reality within which these specific events are occurring. Both the universe as a whole and the human experience of it are subsumed within a theological paradigm that has important cognitive and psychological connotations for believers.

Muslims should regularly reassure themselves about God’s beautiful qualities and the ultimate wisdom of His actions in his creation, by recitation and contemplation of scripture. The Qur’an reminds us that He is All-Knowing and
All-Aware (4:35), closer to every human than their own life essence (50:16). The dominion of the heavens and earth are His (36:83), and nothing afflicts humankind save by His leave (64:11). It is He who is the Healer (26:80), who does not burden any individual with more than they can bear (2:288), He upon whom the believers rely utterly (3:122) and He who is Ultimately Benevolent and Merciful (1:2).

From a theological perspective, the general Sunni consensus is that the only true metaphysical agent of causation is God, in accordance with His pre-eternal decree. Methodologically (and juristically), however, ‘natural’ laws of causation are considered to be actionable. This is summarised in the famous hadith of contagion: ‘there is no (true) contagion or ill-omen, but keep your distance from the leprosy-affected’ (Sahih Muslim). In other words, pragmatically and in derivation of ethico-legal judgments, one operates on the basis of scientific and empirical norms, whilst affirming that true causation is effected by God, not laws of nature.

These verses and principles serve to remind us of the realities underlying our present circumstances; we make moral choices to the best of our ability, but the outcomes of these decisions are beyond our control and subject to His. They also give us resolve that while we may be tested and endure hardship during this pandemic, these trials will not break us and that deliverance from them will come from Him, as He reassures us, ‘with hardship comes ease, after hardship comes ease’ (94:5-6).

4.2 Islamic Bioethical Principles of Seeking and Providing Treatment

The dominant position across the classical Sunni schools of law, and contemporary fiqh councils, is that seeking medical treatment is a permitted act, and becomes obligatory in circumstances that were considered rare in medieval times, but are far more common in modern times. A synoptic and critical reading of the tradition indicates that, in seeking treatment, the legal ruling revolves around the degree of certainty of the proposed treatment.
being curative and/or removing disease-related harms. Such matters are adjudged empirically in terms of a 'hierarchy of probability' (*maratib al-dhann*) – from certainty to unlikelihood. In other words:

- Where the benefit of treatment is highly likely (*ghalabat al-dhann*) or near-certain (*yaqin*), it becomes **obligatory** to avail oneself of the cure; this is considered equivalent to eating to ward off starvation.
- If the benefit is more likely than not (*dhann*), it is at most **recommended** to seek it.
- If benefit is equivocal or unlikely, then the ruling becomes one of mere **permissibility**.
- In cases where the proposed benefit is highly unlikely to accrue, and physical or other forms of harm likely to occur, it may be considered **recommended** (*mandub*) to forgo the treatment. An example of this – DNACPR orders – will be mentioned below.
- Lastly, where resources are limited and others are more likely to benefit the treatment than oneself, it would be considered a highly meritorious act to refuse treatment in favour of affording it to another (this relates to *fiqh al-inghimas* – or ‘the ethics of self-sacrifice’).

Indeed, according to the overarching legal maxim, the removal of harms is prioritized over the procuring of benefits (*dar’ al-mafasid muqaddam ‘ala jalb al-masalih*), which accords with the Prophetic statement, ‘let there be neither causing nor reciprocating harm in Islam (*la darar wa la dirar fil Islam*). (Ibn Majah)

Some contemporary scholars add to this view that seeking medical treatment may become obligatory because of the **communal** benefit that would accrue – when not being treated would cause inter-personal harm and a treatment is available, e.g. in the case of an infectious disease, or not being treated would result in disability that would impede one’s ability to provide for one’s family. These latter views are grounded in juridical concepts of promoting public interest (*maslaha*), protecting life (*hifdh an-nafs*), preserving human dignity (*hifdh al-ird*), and related legal maxims.
Specifying these general views to Covid-19 requires cognisance of the following:

i. **There is no known cure** or treatment for the disease, rather all treatments aim at supporting the individual such that the body’s immune system to fight off the virus, and

ii. **Outcomes of severe illness are poor:** in the case that Covid-19 disease leads to respiratory failure and requires a patient be intubated and placed on a ventilator management, over half of individuals requiring such treatment will not survive to hospital discharge.

iii. **Some types of people have worse outcomes:** characteristics associated with such dismal outcomes are individuals with pre-existing lung disease, high blood pressure, immuno-compromise, or multiple chronic diseases, and especially the elderly. Up to 75% of such patients do not survive ICU, as opposed to 30% of younger and fitter patients. These latter data-points are based on emerging data from case series, and may change as our ability to treated Covid-19 patients improves.

With full cognisance of the above, presently an Islamic bio-ethical position would not religiously obligate patient or clinicians to opt for either initiation or continuance of **intubation with ventilator** management, when physicians or protocols suggest such treatment will not yield clinical benefit. This is because, as noted above, there is neither certainty nor even high likelihood of life-saving benefit. At the same time, the process of intubation and ventilation is highly invasive and unpleasant, with its own negative outcomes. Thus one could argue that the overall harms outweigh benefit, in that death is the likely outcome either way; all that is left to determine is the likely manner and circumstances of death – whether an ICU or quieter and more peaceful environment. This relates to the Islamic legal maxims that harm should be avoided or removed, and that a lesser harm should be preferred over a greater one.
The same principles of probability of utility/futility and benefit vs harm apply to the question of Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) orders. Presently patients are being asked to consider this on admission in many hospitals. Cardio-Pulmonary Resuscitation (CPR) is a last-resort measure in cases of cardiac arrest (the heart stopping), which hopes to restart the most vital human functions in order to allow more advanced management in ICU. The likelihood of ultimate survival post-CPR is poor – less than 10% if performed outside an ICU and 25% if performed inside ICU, according to the Resuscitation Council. It is also an aggressive procedure, with research indicating that at least 40-70% of patients suffer rib or sternal fractures as a result of chest compressions, and intubation often required. Given the above, a cogent Islamic bioethical position would be that it is permissible – and in the case of the elderly or infirm, possibly even religiously recommended – to opt for a DNACPR order. This is given the poor likelihood of survival and high likelihood of infringements of human dignity and bodily inviolability during the (probably futile) CPR process.

4.3 Islamic Principles of Social Equity and Human Worth in Healthcare

From an Islamic perspective, it should be recognised that each and every member of the human race is endowed with inviolability (hurma) and dignity (karama). Modern scholars have noted that Islamic jurisprudence has the longest uninterrupted tradition of universal human rights in human civilisation (the so-called ‘huquq paradigm’). The Qur’an states unequivocally that God “has honored the children of Adam” (17:70), and commentators on this verse note that this ‘honoring’ is inclusive of all members of the humankind indiscriminately.

As such, all humans have the same intrinsic worth, and accrue the same right of being preserved from harm (ie: negative rights). Within this agreed rubric, Islamic scholars accept the notion of differential social worth as a general concept, though are divided on how it may or may not be used, given that various positions can be justified from within the legal tradition.
It is also notable that although this ‘worth to society’ may sometimes be legally construed in narrow financial terms, a broader view of the Islamic tradition provides a holistic view of human worth, encompassing for example: the benefit the elderly bring through accepted supplication, stay-at-home women raising the next generation, and the vulnerable and weak in society in terms of drawing Allah’s mercy to the community as a whole. A faith community’s conception of human or social worth is thus markedly different from a secular and materialistic one.

Thus as a general rule, even in times of scarcity, prioritizing humans based on their supposed instrumental value to society threatens notions of *karama* (dignity), and harming them by removing life support on such a basis would be an affront to *hurma* (inviolability). Additionally, the scales in which such social worth might be measured are so diverse as to render the concept unusable in any practical sense.

In other words, whilst the law accepts social differentiation in some positive rights (relating to acquiring benefit, such as some specifics of zakat, marriage, and inheritance), it makes no differentiation between humans in negative rights (related to averting harm, such as the current case). Prioritization of access to ARS in the current pandemic on the basis of non-clinical notions such as social worth or in/out-group membership, would not be permitted in normative frameworks of Islamic law.

An Islamic bio-ethical approach to resource ethics and policy recommendations should reject frameworks that are based on value judgements about differential intrinsic worth or instrumental value of people to society. As noted above such considerations are an affront to theological notions of human dignity and inviolability.

Moreover they may constitute discrimination against the most vulnerable in society, such as the disabled and marginalised. Indeed, Islamic law leans towards according extra protections to more vulnerable populations so that injustice is not perpetrated. Similarly Muslims should advocate against prioritisation purely based on a social class.
That said, there is long historical precedent in the tradition, and sufficient flexibility within the Islamic maxims, to make decisions that facilitate maximizing benefits and minimizing harms to society at large, especially in times of scarcity. Given equivocal clinical benefit, advocating for preference on the basis of an individual having rare or irreplaceable skills that might alleviate harm from many others can be adjudged acceptable in Islamic law on the basis that ‘communal benefit supersedes individual benefit’, and that ‘lesser harm may be committed to ward off greater harm’.

However, even if the tradition can be used to justify that a healthcare worker can be prioritised because they can help save other individuals who are stricken with Covid-19, not all healthcare workers have the same community benefit to offer; a clinician is different from a technician and a dermatologist is different from a surgeon, and so forth. If required, therefore, Muslims should advocate for individualised prioritisations and ones not based on class.
5. Counsel to Patients and Families

In this time, where death seems ever-present and we fear losing our loved ones, we remind ourselves about the believer’s views on death and the importance of preparing for it. Death is a bridge between this world and the next, a return to our Lord, and fixed point that can neither be brought forward an hour nor moved back. Cognitively, we have firm belief that death comes at the exact time, place and manner appointed for us, and no death is before its time. Emotionally, we trust in the wisdom of our Lord, who gave us life and will also give us death, and await it with dignity, serenity and hope in His mercy. Spiritually, we await the summons, ‘O soul at peace! Return now to your Lord, well-pleasing and well-pleased; enter now my garden in the company of my beloved worshippers!’ (89:27-30).

Whilst embodying all this, however, we make preparations for a good life, a good death and a good afterlife. This includes taking preventative measures for ourselves and those around us to minimize the risk of illness, seeking medical treatment when needed, laying out our wishes and bequests in a will – including any advance directives about what steps one would wish to be taken in extremis (like resuscitation) and funeral arrangements – as well as rectifying our relationships with those around us, and seeking our Lord’s mercy and forgiveness with hope and certainty.

It is also important to reflect, individually and as families, about what one considers to be a ‘good death’ and how about one seeks to bring it about. These (difficult) discussions might include whether an individual might give preference to dying surrounded by family in a peaceful environment, such as home or one of the palliative care ‘hospices’ that are being set up, over the possibility of survival with advanced medical techniques.
As such, we would make the following recommendations:

- Everyone – whether or not they are considered ‘high-risk’ – should make adequate preparations for their demise, including writing up an Islamic will (simple templates are available online), considering advance directives about DNACPR and whether one would want ARS. This should include information about debts to man and God, such as missed prayers, and should be clearly written down and stored. This is in addition to spiritual preparations for the meeting with one’s Lord.

- It is permissible to opt for a DNACPR order, as well as to opt to refuse ICU admission or advanced respiratory support if one is declared by a clinician to be in a high risk category unlikely to benefit from these options.

- If patients (or their families) are told they will not be intubated or placed on a ventilator, they should rest assured that God is in control of all things and can effect healing with or without any intervention as He pleases.

- It is permissible for a family member (or surrogate decision-maker) to assent to the withdrawal of life support because clinicians find the ICU patient to not be improving. In cases where such decisions are made without family consultation due to resource allocation algorithms, Muslims should recognise the exceptional circumstances being invoked and trust that each person’s time of death is appointed and that nothing befalls a person without the leave of God.

- It should be noted that none of the above would be considered either active assent to euthanasia or suicide, but rather taking an informed decision about offering or receiving treatment and thereafter leaving one’s affair to God – as indicated in the Quran: ‘…and consult with them regarding the matter; then, when you have made a firm decision, place your trust in God…’ (3:159).

- Given the dire circumstances that may be coming related to resource allocation and end-of-life care decision-making, we urge Muslims to have candid and frank conversations advanced care planning conversations now. Specifically, one should consider what sort of minimal physical state they desire for themselves and set that as the goal of care that their family can relate to clinical care teams.
6. Counsel to Health Care Professionals

The British Board of Scholars & Imams (BBSI) recognises the incredible contribution and self-sacrifice being made by all emergency services, primarily healthcare professionals who are putting themselves directly in harm’s way in order to help others. This is the purest expression of compassion and courage to be found in the world today. We take the opportunity to remind ourselves and them that “God is at the service of His worshippers as long as they are at the service of others,” (Sahih Muslim) that “He loves those who go above and beyond in goodness” (2:195) and that “the selflessly compassionate will receive the mercy of the All-Merciful.” (Tirmidhi) We wish to extend our heartfelt thanks, admiration and support to you, and assure you that you are constantly in our supplications.

We also recognise that this is an extremely difficult experience – comparable to a wartime emergency – for those on the frontlines. Clinicians are rightly concerned about their own health given the lack of adequate PPE, demoralised and disheartened by their seeming inability to treat patients, having to make deeply uncomfortable life or death decisions, and working at full pelt, sometimes in areas outside of their specialty. Retired clinicians have returned to frontline work, and newly trained students have been drafted in to face a maelstrom.

Reflecting on and caring for your physical and mental health in this situation should be paramount, as there is a very real possibility of burnout and significant mental distress. Speaking regularly to supervision groups, friends and colleagues – but also hospital chaplains, Imams or mental health professionals – is highly advisable. Clinicians should not assume that – merely by dint of being professionals – that they should be ‘able to handle it’: no amount of training can prepare a person for such an unprecedented situation as this.¹
From a bioethics perspective specifically, it is important to differentiate the moral duties of patients and their surrogate decision-makers (families), from those of healthcare workers and clinicians. The critical difference is that of autonomy: there is a big difference between deciding for oneself and deciding for another. Hence while a capacitous patient may choose, on a conscientious basis, to abstain from a course of treatment that is fairly likely to bring about significant benefit, a clinician cannot arbitrarily choose to withhold that same treatment without good reason. This is fully in keeping with the codes of medico-legal ethics of health professionals, particularly the consideration of what is in the best interests of an incapacitous patient.

Personal autonomy is highly valued in Islamic thought – though not entirely free given one’s responsibility to one’s body before its Creator – whilst decisions taken on another’s behalf fall under the remit of being entrusted to take care of another’s valuables (fiqh al-amanat). This is well-explored in juridical literature, though usually from the perspective of preservation of wealth rather than health and to a lesser extent in classical works of medical ethics (adab al-tabib), which interestingly also detail the ethics of physicians taking decisions against the wishes of their patients.

The general Islamic approach to the ethics of patient decision-making in such times of resource scarcity is summed up in the Quran: “God commands you to faithfully bring forth to their owners that which has been entrusted to you, and that when you decide between people, to do so justly. How excellent is what God exhorts you to! God is All-Hearing and all-Seeing” (4:58).

From the perspective of Muslim clinicians at the frontlines, therefore, we offer the following guidance and recommendations:

- A nuanced approach to implementing clinical and resource allocation algorithms and withdrawing or withholding life-support apparatus and the like is justifiable, on the basis of clinical judgments of utility/futility, measured in the ‘hierarchy of probabilities’.
We recognise that clinicians are working under the laws and policies of the land, and may be operating under different contexts and circumstances. As noted above, where clinical benefit is used to differentiate among patients receiving scarce resources, Muslim clinicians can find solace that their tradition aligns with such views.

Such clinical algorithms are considered to reach the grade of dominant probability (ghalabat al-dhann) in Islamic legal lexicon and can be utilized. Indeed, given that probability of mortality is high despite intervention (>50%) there is sufficient Islamic rationale to withhold life-sustaining interventions as the probability of harm is certain, all clinical interventions disrupt the body and thus in some fashion impact hurma (inviolability), whilst the likelihood of benefit is low.

Moreover, doing so may lead to communal harms, as they lead to scarcity of resources (PPE, ventilators, clinicians), which can be detrimental to other potential patients. Here maxims such as ‘an individual harm being tolerated in lieu of a public harm’ and similar are invoked.

Similarly, it is permitted to withdraw life-support in the same scenario where a patient has low probability of recovery (based on clinical decision tools). In this case, one could argue that the harms of the treatment outweigh the benefits, given disruptions of hurma (inviolability), and karama (dignity) by being in intensive care, away from family, largely unconscious, and the like.

As far as possible, clinicians should attempt to discuss critical decisions about incapacitous patients with family members.

Claims of conscience are Islamically legitimate, though we recognise that in the highly pressurised circumstances of the pandemic, this is likely to be difficult in practice. Clinicians should, where possible, seek counsel and guidance from one’s peers, supervisors/trust, and religious scholars if one feels uncomfortable about this.
• When probability of benefit is high (likelihood of survival is >50%) then instituting therapy, unless there is specific direction from family/individual not to, is appropriate.

• If a patient or surrogate decision-maker opts not to pursue such treatments, clinicians should respect their choice. Both contemporary medical ethics and Islamic ethics support the idea that patients with decisional capacity (or their surrogate decision-makers) can refuse medical treatment, including life-sustaining measures. Thus patients (or their surrogates) who desire not to be intubated or to have life support withdrawn, are empowered to request so.
7. Counsel to Policy Makers

From the perspective of those – whether clinicians or otherwise – who are in a position to contribute to policies regarding resource allocation, or be charged (at departmental level) with implementing such policies that involve withdrawing and withholding life sustaining measures such as ventilators:

- **Muslims can and should uphold resource allocations based on clinical benefit.** In other words, one can use clinical decision rules to ascertain which patient would have greater longevity or greater reduction in mortality (i.e. stand to benefit more) from ARS and prioritise those individuals. This action accords with multiple Islamic maxims including 'procuring of the greater good by forsaking the lesser,' or 'when two harms meet, commit the lesser to avoid the greater.' It is also in keeping with Islamic ethico-legal principles relating differentiation on the basis of likelihood of benefit (the 'hierarchy of dhann'). Indeed nearly all ethical frameworks adopt allocation protocols using such medical judgement.

- In cases where such critical decisions are made without family consultation due to resource allocation algorithms, one should **advocate the need for clear transparency** and accountability, which take into consideration how the decision was taken, what options were considered, steps taken to consult and how it was communicated to the family.

- Muslims can advocate that, instead of algorithms based on instrumental social worth (when clinical benefit is equivocal), a **lottery-system** or similar system be used. Contrary to common belief, choosing lots is not abdicating moral responsibility, rather it is resolving to leave the judgment in the “hands of God” and is substantiated by the Prophet Muhammad doing so in certain circumstances. An Islamic bio-ethical position would also consider a trial of therapy to be recommended in situations where benefit was equivocal, provided this did not entail depriving a more likely-to-benefit candidate of that resource.
• If there is a requirement to consider aspects of ‘social worth’ as a decision-making tool, in cases where clinical benefit is equal, Muslims can validly advocate for a restricted version of this, wherein prioritising certain individuals on the basis of their immediate benefit to society in this situation (eg: a healthcare worker with rare skills who has the potential to serve the broader public good in this current context) make take precedence. Islamic scholars, both classical and modern, have justified taking such characteristics into consideration under exceptional circumstances based on the removal of the greater harm in lieu of the lesser.

• Given that valid differences of opinion mean that there is no clear ruling (and thus no sin), Muslims can implement such policies in individual cases. However, in such cases one should advocate for clear and transparent decision-making, and strongly caution against a slippery slope of assessing human worth on the basis of apparent and instrumental social utility.

• On the other hand, Muslims who do not feel comfortable doing so are also justified in claiming conscience and referring the specific procedure of withdrawing or withholding to a collaborating physician who has the requisite skill-set. Claims of conscience are part and parcel of some legal systems, such as the UK, but not others, so Muslims need to ascertain their own context. Claims of conscience are justified in the tradition as the Prophet Muhammad (peace be upon him) stated, “Leave that which disturbs your heart for that which brings it solace.” (Tirmidhi)

• Conscience claims become more important in the unlikely circumstance that social characteristics – such as prioritising the able-bodied over those with disabilities – or similar ideas are incorporated into resource allocation algorithms. Finally if claims of conscience are not possible and one is compelled to implement objectionable policies, Muslims should seek forgiveness internally and resolve to find the action odious. As the Prophet Muhammad (peace be upon him) stated “If you see a wrong, change it with your hand and if unable speak out against it, and if unable then find it odious in your heart for this is the lowest level of belief.” (Sahih Muslim)
• The prohibition against any form of direct discrimination that applies in the NHS should be appreciated and supported, but there remains the possibility of indirect discrimination, particularly of minorities or socially vulnerable communities, being disadvantaged. We would strongly encourage those in positions to influence policy to call for clear (and real-time) review of demographic data and decision-making procedures, to ensure that this is considered. We would also encourage that minorities (including Muslims) are represented on ethics committees to lend their voice and perspective to such deliberations.

• On the ground, we would call for trusts to ensure – as far as possible – that steps are taken to cater to the holistic needs of all patients in what is a highly pressured, disorientating, and frightening situation. Where BAME communities are concerned, this should include interpreters to assist with communication between clinicians and patients. We fully recognise the difficulty of this in the current circumstances, and wish to express appreciation for the steps that have already been taken in an incredibly difficult situation.

We pray that this guidance helps to clarify the Islamic bio-ethical position on the provision and maintenance of life-sustaining support and care during the COVID-19 pandemic, and that the recommendations herein bring clarity and comfort to individuals, families, frontline clinicians and policy makers. We pray that God grant holistic wellbeing (‘afiya) in this life and the eternal Life to Come.
Endnotes

1. This is outlined in the Mental Health guide for health workers, imams and scholars, chaplains and therapists: BBSIG-07.

2. The BBSI is there to support you: info@bbsi.org.uk