INDONESIAN COMPARATIVE LAW REVIEW

Volume 2 No 2, June 2020
P-ISSN: 2655-2353, E-ISSN: 2655-6545

Article Info:
Received : 08-08-2020
Revised : 03-11-2020
Accepted : 04-11-2020

http://dx.doi.org/10.18196/iclr.2221

The Laws in Medical Futility: A Comparative Study between the Malaysian, English, American, Indonesian, and Islamic Law

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Abstract

Medical futility has always been a huge blow to the medical world. While medical practitioners live to save others' lives, some cases may not be as kind to their honorable intentions. The problems that were posed by medical futility had always spark issues of morality, ethics and laws. The paper aims to address the laws governing any medical practitioner's actions towards medical futility which is likely to result in the death of the patient. It will look into the current laws of four nations namely Malaysia, England, the United States of America and Indonesia, with special consideration towards Islamic Jurisprudence by referring to the opinions of various scholars and jurists. This paper has come into being through the studies of many literary articles, law cases, analyzing related statutes and studying the common practices of the previously stated nations. The paper had reached some fundamental outcomes which are: Malaysia and its mother land England shares similar practice in which withholding and withdrawal of treatment is considered lawful when faced with medical futility. As for the United States of America, some states adopted laws regulating end-of-life decisions, providing guidelines and proper sanctions for non-compliance which is contrary to Indonesia which do not have a specific regulation in dealing with medical futility cases. From the Islamic law perspective, scholars had advised that heavy consideration should be given according to the Maqasid Syariah by adhering to the hierarchy of fiqh of looking after necessities, then needs, and then embellishments.

Keywords: *medical futility; common law; american law; indonesian law; islamic jurisprudence*

1. Introduction

"Medical futility" may be provisionally defined as a medical conclusion that a therapy is of no value to a patient and should not be prescribed. In another word, it is when a medical practitioner concludes that a treatment is futile and treatment withdrawal is suggested. However, the main issue arose when the patient does not consent to such suggestion and continue to insist on further treatment.

The above scenario result in an obvious conflict in medical ethics with regards to doctor's prescription and patient's autonomy. First, there is a traditional and modern view that a prognostic expert physician should not prescribe therapies which cannot restore health to a dying person. This is nothing but an act of torture to said patient. Second, some would ground this decision-making authority on a physician's duty to not cause pain. And third, the authority of medical futility might be grounded on an appeal to efficiency. For example, futile CPR should not be provided because it is wasteful or not-cost effective to do so. Similarly, a futile treatment should not be prescribed as it is a waste of resource when the facilities

can be benefited by other patients.

Proponents believe that allowing physicians to determine and withhold futile therapies can be done without disturbing the current paradigm of medical ethics which respects patient autonomy with regard to informed consent and the right to refuse treatment. Mostly in cases where patient consent to treatment withdrawal. Others conclude that medical futility is simply an unacceptable form of medical paternalism while some adopt a middle position that doctors can predict medical futility; they believe that attempting this does not necessarily justify imposing decisions to forgo life-sustaining therapy on patients. [1] Whatever the situations are, it is apparent how patient's autonomy is considered greatly which result in certain implications in determining what exactly is best decision to be adopted by law.

In this paper, history and development of laws with regards to medical futility cases will be analysed starting form motherland country Malaysia followed by two other common law countries which are the United Kingdom (England) and United States of (America). A comparative study with the neighbouring country Indonesia will follow suit and lastly concluded with an outlook from the Islamic law perspective

2. Issues Relating to Medical Futility

History has proven that the term "medical futility" is virtually impossible to define.[2] It is harder to decide when the lives of the innocent are on the line. It has always been a controversial issue, as well frustrating. It is basically a story with no villains, just victims suffering from the cruel game played by fate. Even so, a guideline is necessary to facilitate the approach of the matter. Although it may not be the best approach in some eyes, it should be noted, that a lot of considerations are put in drafting the guideline.

Texas was the first ever state to introduce a specific guideline. Other states are urged to consider codifying a concrete futile care policy, as Texas did,[3] in order to limit the dangers of inconsistency and confusion among the United States' jurisdictions. Criticism of the Act, however, alleges that it violates the United States Constitution,[4] therefore implying that the Act should not exist, as is, in Texas or anywhere else in the country. It seems here that regardless of the approach, there will always be controversies as right to life is on the line. Resolving the conflict is a dream of many, but some things are easier said than done.

Some law approaches are criticized and chides though this does not seem to stop the movement. Commentators have generated three kinds of proposals for resolving these conflicts. One group contends that the problem can be solved within the physician-patient-family relationship while some in this group view professional authority broadly enough to warrant unilateral judgments by physicians that interventions desired by the patient or family should not be provided. Others contended that physician authority does not extend that far, and that any resolution must be constrained by informed consent requirements.[5]

[1] D.W. Brock, S.A. Wartman, "When Competent Patients Make Irrational Choices." *New Engl J Med* 1990; 3zz: 1595-1599.

[2] Council Ethical Judicial Affairs, Am. Med. Assn., Medical Futility in End-of-life Care: report of the Council on Ethical and Judicial Affairs, 281 JAMA 937, 938 (1999)

[3] Tex. Health & Safety Code Ann. δ 166.046.

[4] Maureen Kwiecinski, To Be of Not to Be, Should Doctors Decide? Ethical and Legal Aspects of Medical Futility Policies, 7 Marq. Elder's Advisor 313, 342-47 (2006) (arguing that the Act violates the procedural safeguards of the Due Process Clause in the Fourteenth Amendment).

[5] President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral

A second group suggests that the solution lies in the freedom to leave the physician-patient relationship. If physicians cannot discontinue treatment they consider futile, they should be helped to transfer the patient quickly to someone else, lest their consciences be violated.[6]

A third group of commentators believes that futility conflicts ought to be addressed in less individualistic and private terms. Futility conflicts must be, in part, collective decisions based on input from a wider circle of participants. This group suggest the presence of an arbiter in the process of decision-making. Although it is undeniable that physicians, judges and family members play a huge role in deciding what is best for the patient, it is still not sufficient to have them solely deciding on the matter.

It is clear how the commentators had put great consideration in coming up with the suggestions. It is still as clear as water how these suggestions may not sit well with some groups of people. As mentioned, the parties are merely victims with no one to blame. The best answer would be to find a cure altogether. But since that option is still out-of-reach as of now, the society needs to come to a consensus on how to deal with the dilemma. In a liberal society, physicians should be guided by consensus-driven rules on limits to health care. Since no consensus exists currently, he urges physicians to avoid unilateral decisions that would terminate desired treatment.[7]

3. The Laws Regarding Medical Futility

3.1. Laws in Malaysia

In Malaysia, medical futility cases are often found in withdrawing or withholding treatment. According to the General Medical Council of the United Kingdom, withdrawing and withholding of treatment occurs when, "the life sustaining treatment of a patient is no longer needed, or where it has become a burden on such patient." [8] This act is associated with passive euthanasia. Passive euthanasia can be "voluntary", where the conscious patient authorizes it, or if unconscious, the patient had communicated to his next of kin that he would prefer not to be kept alive on life support.[9] It can also be "non-voluntary", where the decision to withdraw life support is made by the family of the patient. However, it could also be "involuntary" in a case when the decision is made against the patient's wishes.[10]

On the issue of euthanasia, the Malaysian ethical codes and law have yet to develop to the fullest extent. Presently, any deliberate act at taking active steps, at either causing, or hastening the death of a patient, would amount to committing murder under section 300 of the Penal Code (Amendment) Act 1989 [Act 727] if it has been performed against the wishes of his patient.[11] Even if the patient consents, the offence of culpable homicide would have been committed under section 299 of the Penal Code (Amendment) Act 1989 [Act 727] as it is a direct violation of the principle of sanctity of life.[12] However,

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Research, Deciding to Forego Life-Sustaining Treatment (Washington, D.C.:U.S. Government Printing Office, 1983); D.L. Scheidermayer, "The Decision to Forego CPR in the Elderly Patient,"JAMA, 260 (1988): 2096-97; B. Zawacki, Tongue-tied in the Burn Intensive Care Unit," Critical Care Medicine, 17 (1988): 198-99; and Giles R.

[6] Judith F. Dear, 'A Clash at the Bedside: Patient Autonomy.

v. A Physician's Professional Conscience, "hastings Law Journal, 44 919930: 1241-89

[7] Troyen A. Brennan, "Physicians and Futile Care: Using Ethics Committees to Slow the Momentum," Law, Medicine & Health Care, 20 (1992): 336-39

[8] http://dvina.about.com/od/alossarv/lwithdraw.htm

[9] Biggs, H., 2001. Euthanasia, Death with Dignity and the Law. Oxford: Hart Publishing; De Cruz, P. 2005 Nutshells on Medical Law. London: Sweet & Maxwell. At pp 216-217

[10] Ibid

[11] Section 300 provides that culpable homicide would amount to murder

[12] "whoever causes death by doing an act with the intention of causing death, or with the intention of

there are no direct provisions dealing with withdrawal or withholding treatment in the Penal Code. But, as there is a clear distinction between a doctor who withdraws treatment intending thereby to kill the patient, and a doctor who does so merely foreseeing that the patient will die; the act of the former will surely be prosecuted.

Despite no laws providing the guideline for Malaysian doctors, the current practice is in several ways quite similar with England in which withholding and withdrawal of treatment is considered lawful where continued treatment is not in the best interests of the patient. Thus, futility of the patient's treatment should always be the overall consideration before treatment can be withdrawn.

3.2. Laws in England

Under the English law, a doctor who deliberately takes active steps to cause death or hasten death of his patient would be committing murder if it had been performed against the wishes of his patient. Passive euthanasia through withdrawal or withholding treatment including withdrawal of nutrition and hydration was held lawful in certain circumstances particularly where recovery was unlikely, continuance of treatment would be futile and not in the patient's best interests.

This issue was discussed at length in the case of *Airedale NHS Trust v Bland*[13] in which The House of Lords contended that active euthanasia remains unlawful as it is a direct violation of the principle of sanctity of life. However, medical treatment, including artificial feeding and the administration of antibiotics, could lawfully be withheld from an insensate patient with no hope of recovery. The case of Airedale necessitated a series of guidelines *(Bland principles)* for medical doctors on withholding and withdrawing of life sustaining treatment. This guideline is later followed by most Commonwealth countries, including Malaysia.

The UK Court of Protection was nevertheless recently asked to resolve a conflict between the family of a Muslim PVS patient who objected to his doctors' intention to withhold resuscitation or ventilation should there be a life-threatening event on the grounds that such measures would be futile and thereby not in the patient's best interests. The family instead insisted that all steps should be taken to preserve the patient's life until such time that God takes it away. This sparks a further debate to look into the adapted Bland principle and its relationship with other challenged rights as stated on the Human Rights Act 1998 and Mental Capacity Act 2005.

Firstly, the principle was challenged in *Re* ***G***[14] and *A Hospital v Sw*[15] where the courts made it clear that the withdrawal of life-sustaining measures from PVS patients is not incompatible with Articles 2 and 3 of the European Convention on Human Rights. As regards Article 2 (the right to life), it was claimed that the analysis in *Bland* was entirely consistent with both the negative and positive obligations embedded within the Article. It was opined that the deprivation of life referred to therein must import a deliberate act, as opposed to an "omission", by someone acting on behalf of the State which culminates in death.

The courts similarly held that no contravention of Article 3 (the right not to be subjected to torture or inhuman and degrading treatment) exists. Where it might be argued that death by starvation and dehydration as caused by the withdrawal of

causing such bodily injury as is likely to cause death, or with the knowledge that he is likely by such act to cause death, commits the offence of culpable homicide."

[13] [1993] 1 All ER 821

[14] Re G (Adult Incompetent: Withdrawal of Treatment), 65 BMLR 6 (2002)

[15] A Hospital v. SW, EWHC 425 (Fai) (2007)

CANH is inhuman and degrading,[16] it was asserted that since the article requires the victim to be aware of the inhuman and degrading treatment which he/she is experiencing, the Article does not apply to PVS patients. This is because they are not believed to be able to feel or appreciate what is happening (i.e., they are insensate or in a state of non-awareness). Thus, the Human Rights Act 1998 was interpreted as being compatible with the principles established in Bland.

The *Bland* principle was also not affected by the need to now assess best interests within the framework of the Mental Capacity Act 2005. In deciding best interests, the 2005 Act expects several factors to be considered. [17] These include, so far as reasonably ascertainable, the patient's past wishes and feelings; beliefs and values that would be likely to influence his decision if he had capacity; and any other factors that he would be likely to consider if he were able to. If the patient, before losing his capacity had decide on treatment refusal, then the hospital is allowed to withdraw the treatment for said patient. It is important to note that although the Act provides for anticipatory decisions, this only refers to refusal of treatment only. The patient or the family cannot therefore demand nor insist on the continuation of life-sustaining treatment through this mechanism.[18]

3.3. Laws in the United States of America

As history suggest, the leading state in developing laws in this area is Texas, the birth state of the very famous and heartbreaking case of *Sun Hudson* [19] . According to bio-ethical experts, the child's death marked the first time an American court has allowed a health care facility to end a baby's life support against the wishes of a parent.[20] Genetic tests showed that Sun was born with thanatophoric dysplasia, which is a rare, fatal condition. On March 14 2005, nearly six months after Sun's birth, the probate judge lifted the court's injunction and allowed the hospital to withdraw life-sustaining treatment from Sun. Ms. Hudson came to the hospital the following day and was holding Sun when he died shortly after treatment was withdrawn.[21]

The Sun Hudson case is of several cases that have sparked a recent controversy over the Texas Advance Directives Act, specifically the subsection of the statute the Futile Care Law.[22] This Act lays out the steps that are to be followed when it has been decided that a patient will not recover, and physicians and families disagree over continued health care measures[23] With this statute, Texas became the first state to adopt a law regulating end-of-life decisions, providing a legislatively sanctioned, extrajudicial, due process mechanism for resolving medical futility disputes and other end-of-life ethical disagreements.[24]

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[16] Anna Nowarska, To Feed or Not to Feed? Clinical Aspects of Withholding and Withdrawing Food and Fluids at the EndofLife, Io Advances in Palliative Med. 3,4 (2011)

[17] 46/d. Section 4

[18] This is Consistent with the scope of self-determination whilst alive, whereby one can refuse a proposed treatment however irrational the decision may seem to others, yet this does not extend to request for treatment see e,g., St George's Healthcare NHS Trust v. S, 3 All ER 673 (1998); Re T (adult: refusal or medical treatment), 4 All ER 649 (1992): and Re B (adult: refusal of medical treatment) 2 All ER 449 (2002)

[19] *Hudson v. Tex. Children's* Hosp., 177 S.W.3d 232, 233 (tex. App. 1st Dist 2005)

[20] Medical Futility In Texas Handling Reverse Right To Die Obstacles Without Constitutional Violation

[21] Truog, R.D. (2009). Medical futility. Georgia State University Law Review, 25(4), 985-1002

[22] Tex. Health & safety Code Ann. δ 166.046; Pfeifer & Kennedy, *supra* n. 3, at 26.

[23] Pfeifer & Kennedy, *supra* n. 3 at 26.

[24] Robert L. Fine & Thomas Wm. Mayo, *Resolution of Futility by Due Process: Early Experience with the Texas Advance Directives Act*, 138 Annals Internal Med. 743, 743 (May 6 2003).

There are inconsistencies though. For instance, in *In re Wanglie*,[25] the district court, ruled that life support continue, as insisted on by the patient's husband. Other jurisdictions during the 1990s decided on futility issues differently.[26] In *Gilgunn v. Massachusetts General Hospital*[277] a court ruled in favor of health providers who asserted that treatment should not b given to a patient who was dying from multiple organ system failure (because such measure were determined to be futile) even though the patient's family asked for it. These jurisdiction' conflicting decisions did not represent a general legal acceptance of a medical prerogative unilaterally determine qualitative futility.

3.4. Laws in Indonesia

Indonesia does not have a specific regulation in dealing with medical futility cases. This explains its unique perspective in approaching the matter, consisting of the *Pancasila* [28] and Islamic perspective. The insights from both perspectives reflect one another in a sense that the faith of patients and physician are considered as major values in deciding end-of-life cases. These perspective however, only covers humanity and spiritual aspect. As for laws, Indonesia do have same written laws that can be referred to.

For instance, the Indonesian Code of Medical Ethics (KODEKI) obliges the doctors to respect all life.[29] Consequently, every doctor must perform competent medical service with complete technical and moral independence, respect human dignity[30] and utilize all knowledge and skills to reduce suffering, but not by ending life[31]. However, life support may be withdrawn or withheld for incurable patient and on whom medical procedures has been proven futile.[32] But the decision must be approved or requested by patient's family.[33] Indonesia also provides law for palliative care[34] which mostly governs on resuscitation. A competent patient in terminal state may refuse resuscitation attempt in the future (advanced directive) or in case where resuscitation cannot cure the patient nor improve his quality of life, based on most recent scientific evidences.

However, family members cannot refuse resuscitation unless on advanced directive, or in special condition, based on written requests of all close family members and requires court decision. Interestingly, Indonesia introduced a Palliative Care Tourism program aims in providing great sceneries to comfort terminal patients in their last moments.

To sum Indonesia's perspective as a whole, active euthanasia is forbidden as it constitutes murder. It also does not comply with Pancasila, most of Islamic scholars, Indonesian Code of Medical Ethic, nor Indonesian law itself. However, passive euthanasia by withdrawing or withholding treatment is still controversial. But it is generally allowed when the patient's "life as a whole' is impossible to recover. Even so, to come to such decision requires strict discussion with legal substitute (usually family) and multiple doctors from different disciplines.

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[25] No. PX-91-283 (Minn. 4th Dist. July 1, 1991)

[26] Fine, *supra* n. 59, at 1220.

[27] No. SUCV92-4820 (Mass. Super. Ct. Apr. 21, 1995)

[28] Pancasila: philosophical foundation of Indonesia; consisting of 5 principles: Belief in One and Only God, Just and Civilized Humanity, Unity in Indonesia, Democracy governed by wisdom in representated deliberation, Social Justice for All Indonesian People

[29] Article 1 of the Indonesian People

[30] Article 7a

[31] Article 7d

[32] Article 14 on Decision of Health Minister, number 37 year 2014

[33] Article 15 on Decision of Health Minister, number 37 year 2014

[34] Decision of Health Minister, number 812 year 2007, of "Regulations of Palliative Care"

3.5. Islamic Law Perspective

Issues arising from the withdrawal and withholding treatment have not reached total consensus amongst the Muslim jurists.

According to the majority view of the classical schools of Islamic jurisprudence, which represent the three Sunni schools of law among the four, namely, *Maliki, Shafi ie and Hanbali*, a person can be held responsible for the death of another, even in situations where the accused did not take an active part in the killing of the victim.[35] These scholars based their argument on the fact that their essential needs is denied which results in death. Thus, whosoever caused the denial, shall be responsible for the death of the victim. Thus, even though the accused did not take an active part in killing the victim, but the fact that he detained him in the eyes of the jurists, means he initiates the death and consequently allowing death (withdrawing and or withholding of treatment).[36]

However, a contemporary approach suggests otherwise. *Sheikh Yusuf Al-Qaradawi* and *Siddiqi Muzammil*, are amongst the contemporary scholars who are of the view that since the patient is in an irreversible coma, disconnecting such patient from the machine is in order. Therefore, it is not obligatory to administer medical treatment, which is ruled to be definitely useless or futile, particularly if the patient is brain-stem dead[37] and there is no hope of recovery at all. As the supplies are limited and costly, treatment should be given to those who are able to recover rather than giving to those whose deaths are inevitable. However, even though such medical treatment is withheld, the basic human rights of the patient, which include being provided with food, drink, nursing, and painkillers, must still be provided and this can be done at home. The patient should be allowed to die peacefully and comfortably.[38]

This is a logical thought process which adheres to the hierarchy of *fiqh* of looking after necessities, then needs, and then embellishments[39]. At times of conflict, this tool could help in the decision-making process to resolve the question of whether the seemingly futile treatment can be terminated in order to use the finite resources for the benefit of another human life or to preserve a public resource.

4. Conclusion

Although medical futility had shook the world since the 90's, it remains a controversial matter for all parties involved. Despite the existence of laws, principles and guidelines to regulate the issue, a consensus which is globally acceptable is yet to be achieved hence, in a situation where a life is at stake, end-of-life decision became an unavoidable circumstance which the family patient's especially, are required to put up with. This is not to say that the doctors or judges are the bad guy, because in reality there are none.

Today, the government and judges are being pressured to decide on what constitute justice. Is it the life of a chronic, or investment to public? Though the law is already there but it is still hard to be implemented as there are conflicts with certain rights and interest. We in Malaysia itself, there are no specific law for medical futility hence we follow England's Bland model. Though both countries recognize active euthanasia as murder, passive euthanasia is permissible by

[35] Al-Sharh-ul-Kabeer, lilDurdeer, vol. 4 at 215; Nihat-ul-Muhtaj, vol 7 at 239; Al-Mughni, vol 9 at p. 828.

[36] However, Hanafi, disagreed with the majority view as according to this school, all the accused did was to detain the victim and he did not do anything positive to end his life.

[37] Endorsed by the Third International Conference of Islamics Jurists 1986 in Kuwait.

[38] Islamic Medical Ethics by IMANA Ethics Committee, www.imana.org

[39] Saeed al-Harbi, Fiqh a-muwazonah wo hajot a-Imam wo a-khatib lahu.

law despite it deprived the patient of its right to life. In America, despite being the leading country in passing laws in dealing with medical futility, we can still observe the inconsistencies of the implementation throughout several jurisdictions of the court. This is to say that, despite having a specific law, implementation is not as easy and is always debatable in courts.

Indonesia on the other hand rely on patient's autonomy. It is clearly stated in the laws that consent from the patient or family members are needed to withdraw or withhold medical treatment. In some cases, the family members even requested for withdrawal of life support. This may be a result of prior request by the patient or financial constraint as family members can no longer afford the cost. However, the general rule is that it is permissible even looking at the Islamic perspective. Though most classic scholars do not legalize passive euthanasia, (with the exception of Hanafi) a contemporary approach suggests otherwise. It is more practical to adopt the contemporary approach as it considers the present time circumstances. It also adheres to the discipline of *fiqh*, the *Maqasid Syariah* which tells us to priorities the public interest over private interest.

To conclude the intentional taking of life which requires active commission is unlawful in every countries. However, omission that may result in death is permissible, even in Indonesia which regarded illegal omission as a crime. Even so, this issue will remain to be controversial until a globally acceptable and recognized law emerged.

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