Islamic Ethical Considerations on Medical Decision-Making in Adolescence

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Abstract

Medical decision-making in adolescence has not been studied in-depth from the Islamic bioethics perspective. The objective of this dissertation is to use the Islamic ethics position to explore the adolescent medical decision-making process in Canada so as to contribute to building frameworks for Islamic bioethics consumers such as patients, physicians and policymakers. A descriptive literature review was conducted to analyze data from related disciplines such as Islamic theology, developmental psychology, law and clinical ethics through principles of Islamic ethics such as objectives of Sharia, legal maxims and operational maxims. The concepts of taklif, ahliyya, bulugh and rushd were focused on due to their criticality in judging moral, religious and legal obligations of the adolescent, as well as adolescents’ decision-making capacity. Our research shows that approaching the process of adolescents’ medical decision-making in Canada from an Islamic ethics perspective involves certain factors. These include intention of medical intervention (daruri, tahsini or haji), adolescents’ competence and emotional maturity, potential benefit/harm of the procedure, and their family’s role in decision-making. A guideline using Islamic ethics featuring ‘questions to ask’ was then prepared for healthcare workers regarding adolescents’ medical decision-making in Canada.

Keywords
Medical decision-making, adolescence, Islamic bioethics, competence, mature minor
Summary for Lay Audience

Adolescents are in a transition stage between childhood and adulthood. This sometimes confuses others about how to treat them when they need to make a health-related decision, and conflict often occurs regarding how much say they should have in their own treatment. This dissertation explores adolescents’ medical decision-making from an Islamic perspective by focusing on the faith’s guiding ethics principles. Although the medical decision-making matter is presented through examples from different countries, the study is limited to the Canadian context. According to our research results, a medical intervention should be judged according to the intention that it is invented to serve. The adolescent’s intention in considering that intervention also matters. Did they choose that intervention for treatment or aesthetic purposes? If aesthetics, how necessary is it in terms of physical and psychological benefits?
Questions should also be asked regarding the competence and emotional maturity of the adolescent, potential benefits and harms of the procedure, and family’s role in the decision. Where relevant laws exist, they are applied. However, when no regulation exists nor recommendation from common law, the responsibility for judging adolescents’ decision-making competence is left to health care workers. Our research provides questions significant in Islamic ethics as a guideline for health care workers.
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# Table of Contents

Abstract.............................................................................................................................ii
Summary for lay audience.................................................................................................iii
Acknowledgments..............................................................................................................iv
Table of Contents.............................................................................................................v
List of Figures..................................................................................................................vi

1. Introduction..................................................................................................................1
   1. A. Research Question and The Main Argument.........................................................1
   1. B. Methodology..........................................................................................................2
   1. C. Significance...........................................................................................................3

2. Adolescence in Traditional Islamic Theology...............................................................5
   2. A. Introduction ..........................................................................................................5
   2. B. Taklif......................................................................................................................6
      2. B. 1. Ahliyya ...........................................................................................................9
      2. B. 2. Developmental stages in Islamic Law ............................................................11
      2. B. 3. Adolescence in Traditional Islamic Thought ..................................................15
      2. B. 4. Impediments to Ahliyya .............................................................................20
   2. C. Adolescence Profiles from Islamic History .........................................................22

3. Adolescence in Psychology ..........................................................................................26
   3. B. Adolescence Brain Development and Decision-Making .....................................31

4. Adolescence Medical Decision-Making in Canada ......................................................38
   4. A. Adolescence Decision-Making in the Medical Context ......................................39
      4. A.1. Approaches to Medical (Clinical) Decision-Making .......................................40
      4. A.2. Adolescent’s Capacity in Medical Decision-making ........................................42
   4. B. Legal Regulations Regarding Adolescence Medical Decision-Making ..........48
      4. B.1. Adolescence Confidentiality ........................................................................53

5. Islamic Bioethics on Adolescence Medical Decision-Making ....................................57
   5. A. Islamic Bioethics as a Growing Discipline.........................................................57
   5. B. Islamic Ethics Sources.........................................................................................64
   5. C. Adolescence Medical Decision-Making from an Islamic Ethics Perspective in the Canadian Context ...............................................................75
      5. C. 1. Taklif/ Trusting Reason/ ‘Certainty cannot be overturned by doubt’ ..........76
      5. C. 2. ‘Matters will be judged by their intentions’ ...............................................80
      5. C. 3. ‘Harm must be eliminated’ ......................................................................82
      5. C. 4. Maqasid al shariah .....................................................................................83
   5. D. Guideline for ‘Questions to ask’ in Adolescence Medical Decision-Making from Islamic Ethics Perspective in Canada .........................................................85

Conclusion ......................................................................................................................89
Bibliography..................................................................................................................95
List of Figures

**Figure 1.** ‘A schematic representing a common naturalistic choice’ ........................................34

**Figure 2.** Prefrontal Cortex development models ...........................................................................36

**Figure 3.** Practical steps for assessing and supporting adolescents’ capacity for autonomous decision-making ..................................................................................................................48

**Figure 4.** ‘Identification flow of technological implications according to maqaṣid al-Sharia-based Islamic bioethics’ ........................................................................................................67

**Figure 5.** Application of maslaha in bioethical issues ...........................................................................74

**Figure 6.** ‘Questions to ask’ from Islamic ethics perspective when adolescent individual involved in medical decision-making ........................................................................................................87
CHAPTER 1

INTRODUCTION

This thesis project aimed to examine adolescents’ medical decision-making from an Islamic ethics perspective. An interdisciplinary approach was adopted to tackle this issue since it required understanding adolescent autonomy, related ethical considerations in Islamic theology, exploring adolescence as a developmental stage in psychology and investigating adolescent accountability in the legal aspect. Furthermore, resorting to clinical ethics data was necessary to capture the current applications and discussions in this subject when relevant.

Islamic theology provides a perspective about children’s intellectual and moral maturity and guides in making decisions in ethically conflicted situations. This study’s purpose was to investigate the Islamic ethics approach to this complicated subject, thus contributing to building a framework for Islamic bioethics from which Muslim clinicians, parents/families and policy-makers can benefit regarding the adolescent individual’s involvement in their health-related decisions most efficiently.

A descriptive literature review was conducted, including Islamic theology, developmental psychology, Islamic law, modern law in the Canadian sphere, and bioethics sources. For adolescence, World Health Organization (WHO)’s reference is used which includes 10- to 19-year-old individuals; younger and older persons were out of scope. Adolescents not competent to make decisions due to a mental health condition were excluded from the study as well. While the study's focus for current legal regulations was limited to Canada, references from other countries were addressed when relevant.

1. A. Research Question and the Main Argument
Deliberate analysis is required to weigh the benefits and costs of adolescent individuals’ involvement in decision-making regarding their own health due to the nature of adolescence as a transition period from childhood to adulthood. Health emergencies require particularly quick action; thus, it helps to have a decision-making model ready at hand. Adolescents’ competence, accountability and ethical considerations regarding the medical situation play a significant role in their involvement in this process. This research’s objective was to suggest that Islamic ethics can offer a valuable perspective to facilitate a deeper understanding of the adolescent’s moral maturity and determine the significant factors that should be considered before deciding in a medical context. The study’s second objective was to suggest that Islamic ethics could contribute to developing a model for adolescent medical decision-making by providing ethical tools that advise how to prioritize varying factors in this process.

1. B. Methodology

The method for this research was to analyze the literature review of Islamic theology, psychology, law and clinical ethics regarding adolescent development, moral maturity, accountability, and competence in decision-making, thus building a holistic approach to an adolescent decision mechanism in a medical context from an Islamic perspective. The literature review was conducted in academic databases such as PubMed, Scopus, Index Islamicus and other relevant academic sources.

Islamic primary resources and classical writings were reviewed to derive ethical principles regarding the topic. Some primary or secondary sources regarding Islamic law were used through their Turkish translations due to Turkish being the primary language of the researcher. Islamic theology literature was reviewed to investigate ‘adolescence competence’ in different contexts. For instance, competence in a legal context from the perspectives of the main schools of law were studied. The study is restricted to Sunni sources; however, Shia sources (or scholars’ views) are consulted when relevant. Four main Islamic schools of law are referred to such as Hanafi, Hanbali, Shafi’i and Maliki.
Two main schools of theology (Ash’ari and Maturidi) are referred to due to their commonality; however, other schools are addressed as well when needed.

Developmental stages were also examined in Islamic law regarding their relevance to competence and capacity of decision-making. Furthermore, adolescent profiles in Islamic history were reviewed to understand how adolescents were approached in the early Islamic period to make conclusions about their moral maturity in making important decisions. This review was expected to allow comparing and contrasting perceptions towards adolescence between different societal contexts.

Developmental psychology literature was reviewed to investigate empirical data regarding adolescence. Although the Western psychology approach to being human is problematic according to some Muslim scholars (Haque 2004), our study relied on developmental psychology findings due to the essential role of recent cognitive development in adolescence in our research question while no relevant research existed yet in Islamic psychology. Legal status of adolescent individuals was reviewed through literature of modern law sources. Despite provinces in Canada having different regulations, this review was expected to aid in a comprehensive look into adolescence with the concepts of competence and maturity in legislation.

Islamic ethics sources are reviewed in order to gather ethical considerations regarding the issue. Islamic ethics is the ethical system that is derived by the teachings of the Quran and the words and actions of the Prophet Muhammad ﷺ and other Islamic sciences. Two main approaches are used in Islamic ethics studies: principlist approach and adab literature. This study focuses on principles of the Islamic ethics; thus, follows a principlist approach.

Lastly, clinical ethics literature helped to understand the mainstream approaches, current applications and discussions in the field. A clinical ethics review aided to see where Islamic ethics could serve to find responses to the questions in medical ethics regarding decision-making as well as developing an ethical framework for Muslim specialists in clinical settings. Thus, the comparative element in the study
between clinical ethics and Islamic ethics aimed at leading towards innovative conclusions.

1. C. Significance

While studies exist regarding legal regulations or clinical ethics research when dealing with Muslim minor patients or adults, adolescents’ involvement in medical decision-making has not been studied broadly from an Islamic ethics perspective. Thus, this study was intended to contribute to building a systematic approach towards that demographic group.

Secondly, this thesis can guide in building frameworks for clinical applications derived from Islamic ethics for Muslim patients, practitioners, and policymakers. Pediatric clinical ethics present culturally diverse approaches; however, these are mostly based on consideration of cultural practices of Muslims, not on an application of an Islamic bioethics model (Hedayat and Pirzadeh, 2001) that would allow clinicians to use Islamic ethics guidelines when dealing with Muslim patients. Thus, another significance of this study is the potential contribution to the still-emerging field of Islamic bioethics.
CHAPTER 2

ADOLESCENCE IN TRADITIONAL ISLAMIC THEOLOGY

2. A. Introduction

The Quran has stories of prophets and other significant people where some adolescent profiles are presented. Prophets Ibrahim and Ismail are among the youth where the Quran refers to their astute character. Prophet Ibrahim is mentioned as being blessed with ‘sound judgment’ at an early age (Surat al-Anbiya, 51): “And indeed, We had granted Abraham sound judgment early on, for We knew him well ´to be worthy of it´.” In the same surah (chapter), Ibrahim is also referred to as fatan (young person). He fought against blasphemy in his community, including confronting his own father (Gürel 2011, 12). Even though his exact age is not mentioned, he is assumed to have been between 15-18 when referred to as having ‘sound judgment’ (Günay 2003, 26). He is portrayed as strong and young, fearlessly fighting for his belief. Different narratives are reported in al-Tabari (d. 923) and al-Zamakhshari (d. 1143) where young Ibrahim challenged the belief of the society and the authority of his time (Köksal 2004, 148-153).

Prophet Suleiman is thought to have been eleven years old when he adjudicated regarding the crops ruined by sheep. It depicts his father discussing the issues with him and that he was blessed with high intelligence early on (Günay 2003, 26).

In Islamic law, moral and religious responsibilities begin with the person’s reaching adolescence. The term ‘taklif’ is central to understand why adolescence is a milestone in human life and to discuss intellectual competence at that stage. In the next session, taklif and related concepts will be discussed in-depth along with developmental stages in Islamic law.
2. B. Taklif

The rights, responsibilities, and charge of duty of a human being in Islamic law collectively fall under taklif, and every human being is mukallaf (one who has taklif) unless exempted (Hallaq, 2009). The word taklif (تکلیف) is the past tense infinitive form of an Arabic verb (كلّف) meaning ‘to command someone with a burdensome task’. The terminological meaning of the word taklif is compatible with the literal meaning, referring to the demand or burden given by Allah (Kozali 1998, 13-14).

Two Sunni schools (Ash’ari and Maturidi) held different approaches regarding taklif. Ash’ari jurists claimed that taklif is a challenging demand on the mukallaf as inferred by al-Baqillani (d. 1013)’s definition: “imposing on [the servant] what the servant finds a burden and hardship in.”. Abu Hamid Al-Ghazali1 - a well-known philosopher, mystic and jurist of Sunni Islam (d. 1111) - stated that the taklif content is simply a burden that the individual takes to please God. Al-Juwayni (d. 1085) claimed that taklif should be understood with its tatwiq (boundedness); thus, it is not a recommendation (nadb) nor discouragement (Alaghbri 2020, 182). However, regarding the freedom to choose to act on taklif or not, al-Ghazali had a different point of view than al-Juwayni (d. 1085). He suggested that free will plays an important role in taklif since without it one could not talk about ‘choosing an action’. He emphasized two qualities as being essential for accountability with taklif: the person must have the intellect and capacity to comprehend the purpose of taklif’s content fully. Al-Ghazali perceived taklif as a suggestion the doctor makes to his patients, in contrast to a master commanding a servant. Thus, according to al-Ghazali, if people follow the instructions, they will find the right path; otherwise, they will face the consequences of their choices. His understanding of taklif did not involve forcing people into an action; rather, it is a recommendation. Al-Ghazali supports his views from the Quran (Surat al-Yunus 108; Surat al-Fussilat 46; Surat al-Jathiyyah 15) (Çetin 2011, 73).

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1 Al-Ghazālī’s full name is Muhammad bin Muhammad bin Muhammad bin Ahmad at-Tūsī (Griffel 2020).
In the Maturidi school, Allah does not give any burden that a servant cannot bear. If the person does not have the intellectual capacity to comprehend the taklif, they are exempt from the responsibility. Such situations are called ‘taklif ma la yutaq,’ which refers to a task that is beyond the individual’s capacity (Koyuncu 2012). The Maturidi school also perceives taklif as a cost that a human being must pay for having freedom to act (Demir 2019, 188). It means ‘being assigned the duty of caliphate’; thus, the person with taklif should perform their actions with this ‘caliph’ role in mind (Demir 2019, 191).

Ad-Dehlawi (d. 1762) reported how scholars argued that the word amanah (trust) in Surat al-Ahzab 72 refers to a person’s accepting the taklif. In this verse Allah says: ‘Indeed, We offered the trust (amanah) to the heavens and the earth and the mountains, and they declined to bear it and feared it; but man [undertook to] bear it. Indeed, he was unjust and ignorant.’ Ad-Dehlawi reported al-Ghazali, Baydawi (d. 1319) and some other scholars as stating that amanah (embracing the responsibility/taklif) would lead to good deeds or punishment because of obedience or rebellion towards that responsibility. The reason that a human being is charged with such duty is the intelligence and capability that they hold. (Kozalı 1998, 18).

Az-Zarkashi (d. 1392) mentioned four components of taklif: the source of taklif (mukallif), taklif (the task itself), interlocutor of taklif (mukallaf or al-mahkum aleyh) and the content of taklif (mukallaf bih) (Kozalı 2006, 252-253). Interlocutor of taklif or mukallaf is a significant term for this study since it refers to the person who could be responsible with taklif.

Six requirements were mentioned by az-Zarkashi that a mukallaf should possess:
1. being alive: a dead person cannot be mukallaf; 2. being a human: animals and nonliving things cannot be mukallaf; 3. intellect (akl): the individual is ‘supposed to deduce the unseen from seen, comprehend the consequences of the actions and differentiate the good from the evil’ (Kozalı 1998, 60); 4. bulugh (adolescence): an individual has to reach adolescence to be mukallaf. Scholars have different opinions about age of adolescence. While some argue it should start with the biological changes,
others think it should start at age 15; 5. comprehension (fahm): this term is related to intelligence; however, sometimes a person lacks intelligence such as if drunk or sleeping; 6. ihtiyar: this condition requires the mukallaf to do the task with their own free-will without external pressure.

Scholars have consensus that the intellect is the most critical feature that a mukallaf must possess. Al-Juwayni stated two reasons why children cannot be mukallaf: lack of intelligence and lack of lust (Kozalı 1998, 61).

Some scholars investigated the ‘fahm’ concept in the context of ‘taklif ma la yutaq’ and claimed that a person should not be charged with a task if they cannot comprehend it. Idrak is another term related to fahm that is mentioned in Islamic jurisprudence, which refers to one’s mental capacity (Keshavarzi and Ali 2021), sensory perception or comprehension (Arnaldez 2012). The Arabic word ‘idrak’ means ‘reaching, arriving, getting mature, bringing together, noticing, understanding and knowing’ (Baran 2020, 299). The person who has idrak is called mudrik (Yakit 2013). Al-Jurjani (d. 816/1413) described idrak as ‘perceiving something as a whole’. Ibn Sina stated four levels of idrak: 1. emotional; 2. imaginary; 3. speculative; and 4. intellectual. The highest level of idrak is intellectual idrak, where the intellect is able to fully perceive abstract things (Baran 2020, 299).

Idrak and bulugh were used interchangeably in some sources since idrak is assumed to be fully developed when the bulugh signs appear (Çolak 2011, 117). Bulugh will be discussed later to understand developmental stages in Islamic law. The significance of idrak and fahm in Islamic law comes from the discussion regarding if ‘a person’s capacity to comprehend’ or ‘a person’s comprehension’ is needed for mukallaf status, since capacity does not always lead to the action. In the Quran (Surat al-Baqarah 2:286), Allah assures that the burden (taklif) is manageable: ‘Allah does not require of any soul more than what it can afford’. It can be inferred that a task would not be given if it is incomprehensible or beyond the person’s limits. Usul scholars stated that the condition for being mukallaf is the ‘possibility to comprehend’; thus, if the person has the capacity to comprehend the task, that qualifies them as mukallaf whether they
actually comprehend it or not. *Qudrah* (power) is used to refer to the necessary tools and conditions that a mukallaf has to possess to fulfill the duties without undue hardship. Two types of qudrah are mentioned in Hanafi fiqh, *qudrah mumakkin* (absolute qudrah), and *qudrah muyassir*. Qudrah mumakkin means the minimum necessary power to fulfill the physical and financial duties for the mukallaf. Another term used with qudrah is *istiṭaʿa*, which is translated as ‘real qudrah’ since it means possessing the power that is needed to fulfill the responsibilities, and ability to use them, whereas qudrah mumakkin means just having this power as potential. As discussed above concerning fahm, having the capacity to comprehend and being able to comprehend are different situations. Istiṭaʿa includes *fiil* (action) alongside the power; thus, it covers qudrah mumakkin but has wider meaning (Kozali 2006). It should be added here that a mukallaf must have the knowledge (*ilm*) regarding the task as well since the ilm is one of the conditions of ‘taklif’. (Kozali 1998, 62; Kozali 2006, 253).

The conditions and components of taklif are explained in this section. It can be concluded that intellectual competence and comprehension are at the core of the taklif context, thus a mukallaf must have certain capacity to oversee taklif. Competence, or in other words capacity, will be investigated in the next section to have a better understanding of what makes a person able to carry the burden of the taklif and become responsible.

### 2.B. 1 Ahliyya

In order to be subject to taklif, individuals need to have competence (*ahliyya*) that allows them to obtain their rights and responsibilities. The word ahliyya comes from the Arabic word *اهلية* (اهلية), meaning ‘competence, power/authority’. One meaning of ahliyya is fitness (*salahiyya*), meaning if a person is ‘ahl’ on a certain subject, that person is qualified to perform or advise on the related matter. In fiqh terminology, ahliyya refers to the required qualities and capacity that one should have in order to hold the rights and responsibilities that Allah has ordained.
In Islamic law, the context of the term is extended to include religious, legal and criminal aspects. (Kozalı 1998, 73; Çolak 2011; Omar 2006, 9).

Ahliyya has two types: *ahliyyat al wujub* and *ahliyyat al-ada*. Dabusi, Sarakhshi and Bazdawi were early Muslim scholars examining these terms in depth. Ahliyyat al wujub (competence for acquisition) refers to the competence one carries before coming to this world (starting from the mother’s womb) (Baydar, 2019). It is also defined as having competence for ‘going into debt’ and ‘obligate’. Ahliyyat al wujub has two types: *ahliyyat al wujub al kamilah* and *ahliyyat al wujub al naqisah*. While ahliyyat al wujub al naqisah only involves the rights in favour, ahliyyat al wujub al kamilah includes rights both in favour and against. According to this differentiation, the unborn child has the *ahliyyat al wujub al naqisah*, which only involves the rights in favour (Kozalı 1998, 76; Köse 2021). The lack of formation and not having physical independence are the reasons for the embryo not having the complete ahliyyat al wujub despite its potential to have the general capacity in the future (Hallaq 2009, 227; Çalış 2004). From birth until the age of *tamyiz* (age of discernment), the child gains the complete ahliyyat al wujub called *ahliyyat al wujub al kamilah*, meaning they now have the rights both in favour and against. (Kozalı 1998, 76; Köse 2021, 97; Baydar 2019).

According to fiqh terminology, ahliyyat al ada refers to the competence that allows a person to use their rights and make legal claims (Köse 2021, 97). Ahliyyat al ada also qualifies the person to face the consequences when they act against the law. For instance, if one cannot make financial contracts without a guardian/legal representative, this indicates that they do not have ahliyyat al ada and vice versa. This type of ahliyya requires the person to have maturity in their thinking and free will, so they can understand the consequences of their actions and choose accordingly. Ahliyyat al ada is a critical term in Islamic law since it aids in evaluating an individual in terms of their capabilities to make conclusions regarding their responsibilities. If an individual does not present the signs of competence despite their mature age, they are exempted from legal punishments; however, they are not allowed to make financial contracts either (Çalış 2004, 73).
To have a better picture of ahliyyat al ada, the developmental stages of a human being need to be understood from an Islamic theological perspective since cognitive development seems to be integral in this context to make judgments regarding competence.

2.B. 2. Developmental Stages in Islamic Law

a. Janin (Fetus) Stage:

This stage refers to the beginning of life prior to birth. The human being is not considered as an independent person in this stage and thus cannot be legally ‘liable’. Although janin gains the rights in their favour such as inheritance, lineage, and benefitting from a will and a waqf (endowment), they are exempt from rights that require consent. Some scholars approve assigning a wasi (guardian/custodian) to accept donations on janin’s behalf; however, the majority do not agree with another person making legal decisions for them (Çalış 2004, 85-89; Köse 2021, 98). Janin only has ahliyyat al wujub al naqisah, meaning they cannot go in debt; nevertheless, they can only have rights in their favour (Kozalı 1998, 79).

b. Childhood

This stage starts with the birth of the child and ends in tamyiz stage. After birth, the child gains legal personhood. It has complete ahliyyat al wujub (ahliyyat al wujub al kamilah) which is not lost till death; however, ahliyyat al ada has not started yet. While the child is not responsible for religious obligatory actions, its guardian can act on the child’s behalf (Kozalı 1998). Children in this stage can face certain consequences of their actions such as harming other people’s properties. Their legal guardians have to pay for the damage on their behalf (Köse 2021, 98).

c. Tamyiz (age of discernment)

The word tamyiz means ‘to differentiate two separate things’, a definition terminologically compatible and referring to being capable of differentiating between

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2 This right of lineage is gained without needing a consent and it is in janin’s favor (Çalış 2004, 87).
good and evil, or profitable and harmful. This ability is developed by reaching a cognitive milestone; thus, the stage starts at the age of seven and ends in bulugh (adolescence). In this period, the child is called *mumayyiz* and has a certain level of comprehension; however, they do not have complete intellectual maturity to be ‘mukalla’ (Çalış 2004, 98-100). Thus, in this stage, the child’s ahliyyat al wujub is complete while they only have ahliyyat al ada al naqisah.

*Mumayyiz* children are not obligated to perform religious rituals; however, it is encouraged to teach them at that stage and help them start practicing (Çalış 2004; Köse 2021). Financial decisions regarding the child are handled differently for *mumayyiz* according to their benefit or harm. There are three categories: 1. The situations that are potentially beneficial for the child such as getting *sadaqa*, *zakat*, donations, or gifts. The child does not need anyone involved in these cases due to the potential benefit of increasing the child’s wealth. 2. The situations that are potentially harmful for the child such as making donations or giving some of the wealth. The child needs a legal guardian’s support in these cases due to their potentially damaging the child’s wealth. 3. Neither beneficial nor harmful situations such as renting things or making trade. These situations have both potential consequences of benefit and harm; however, to minimize the risks of harm, the legal guardian’s consent is required for the child to decide. In this stage, sale or purchase by the *mumayyiz* child is invalid till the guardian’s approval. These types of financial deals as a *mumayyiz* are called *mawkuf contracts* (its validation depends on someone else’s approval). If the guardian trusts the child’s capability in financial dealings and permits their financial decisions, that validates all of the child’s agreements. That child is then called *ma’zun* (مذون permitted) and is able to trade and conduct business without the approval of the legal guardian (Köse 2004, 99).

d. Bulugh

The word bulugh is the infinitive form of the Arabic verb ba-la-gha بلغ and is the synonym of (وصول). When used alone, it means ‘reaching, approaching...ultimate target’. When used with other words (غلام or صبي) it means ‘getting mature’, ‘reaching the necessary level in comprehension’, and ‘having ihtilam (wet dream)’. The
usage of the age of sexual maturity as indicatory of overall human maturity dates back to pre-Islamic Sami tradition where the young individual’s hair was cut upon reaching sexual maturity to mark them as religiously responsible (Dal and Güman 2020, 766). The word *gulam* is used for children in general; however, it means ‘the thirsty person who cannot wait to drink or the sea that starts getting high’ to refer to awakening sexual desire. Thus, according to Günay (2003), theoretically it would be proper to refer to young people 15-18 years old dealing with heightened desires (also looking forward to getting married like a thirsty person in order to fulfill the desires) (9).

In the Quran, the word ‘bulugh’ is not used in its infinitive form; however, other forms do appear and refer to the stages of human life. For instance, in Surat an-Nur (verses 59), the verb is used to refer to bulugh as reaching *hulum* (puberty/sexual development): “When your children reach puberty (al-ḥulum), let them ask leave, as those before them asked leave.” (Shuraydi 2014, 324; Dal and Güman 2020). In a Hadith, bulugh is used to describe a person who reaches maturity. The Messenger of Allah (ﷺ) said: “The pen has been lifted from three; for the sleeping person until he awakens, for the boy until he becomes a young man and for the mentally insane until he regains sanity” (Tirmidhi, 1423). In different versions of that hadith, bulugh is translated as ‘getting sexual maturity, reaching intellectual maturity, reaching the stage of being accountable for sins, and reaching youth’. This hadith seems to be associated with the equating of bulugh with sexual maturity. However, reviewing Arab literature shows that it was perceived as a stage requiring more than just recognizing sexual development signs. An Abbasid period poet Mutanabbi (d. 354/965) mentions a tribe where maturity could be gained only through a heroic act in battle, contrary to just reaching sexual maturity. Later commentaries showed that in Arabi culture it was in fact common to include bravery as a sign of maturity instead of the assumption of bulugh only through sexual maturity (Dal and Güman 2020, 767).

In bulugh, the individual is considered to be transformed from a child to an adult. Thus, they have ahliyyat al ada and Muslim jurists from the four Sunni school have consensus on *al-bulugh* (puberty) as a starting point to be mukallaf (Mohd et al. 2018,
However, their ahliyyat al adais not ahliyyat al ada al kamilah, meaning not complete ahliyya. They have *ahliyyat al diniyyah*, which refers to their full capacity in legal and religious duties (Zahraa 1996). As mentioned above, one expected to observe certain natural signs for individuals to start that stage, such as girls having their first menstruation and boys having their first wet dream. These signs can appear in different ages; however, if not observed, the bulugh starts when both a boy and a girl complete their fifteen lunar years\(^3\), according to most Muslim jurists (Shafi’i, Hanbali, Abu Yusuf and Mohammad from Hanafi and some Maliki). Abu Hanifa accepts 18 years old for a boy and 17 years old for a girl (Mohd et al. 2018). Ibn Qayyim Al-Jawziyya categorized the years of 7 to 10 as tamyiz; however, he acknowledged the individual differences in puberty and avoided to define its beginning (Zia-Ul-Haq 2018).

Some scholars criticized considering certain sexual development signs as indicative of cognitive development. For instance, al-Ghazali said: ‘starting to produce seminal fluid does not increase one’s intelligence’. Based on this argument, while some scholars assume bulugh as the beginning of mukallaf, others require *rushd* (having sound judgment) as well to be mukallaf (or ahliyyat al ada al kamilah) (Çalış 2004, 110).

e. Rushd

The word rushd is the infinitive form of the verb رشد *ra-sha-da*. Rushd means to get and remain on *hidayah* (guidance), which is the antonym of deviance. In the Quran, several words are rooted in it. Depending on their structure, they mean ‘right path’, ‘getting/leading to right path’, ‘right thinking/prudence’. However, the word ‘rushd’ is only mentioned in Surat an-Nisa` 6: “Test ˹the competence of˺ the orphans until they reach a marriageable age. Then if you feel they are capable of sound judgment, return their wealth to them…..”. In this verse, rushd refers to ‘reaching maturity in intellectual capabilities’ (Dal and Güman 2020, 769).

According to Hanafi scholar Al-Zarqa, the terminological meaning of rushd is "the ability to see and foresee risks and accordingly make reasonably good decisions regarding one's own actions and transactions" (Zahraa 1996, 250). A person who has

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\(^3\) Lunar years are not equivalent to solar years. A lunar year is 354 days.
rushd is called *rashid* (Immisch and Dols 1992). A rashid has ‘the capacity to behave in a responsible and constructive manner’ (Hallaq 2009, 239). Legal schools differ in their method of judging mental maturity. Shafii’i and Zahiri schools claim that good character in religious and transactional matters should be the criterion while Maliki and Hanbali think adequate diligence in transactional situations is sufficient to judge the maturity (Zahraa 1996).

While bulugh refers to sexual maturity and is an asset for liability, rushd is used to refer to the age of majority widely used in financial law. Despite varying opinions regarding the indications of bulugh such as the beginning and end of this period, there is consensus that reaching bulugh is the beginning of religious and legal obligations such as being responsible for *ibadah* (worship) and being held accountable in certain criminal actions. However, for financial decision-making, rushd is required, which involves maturity in thinking and experience (Dal and Güman 2020, 763-800). This is based to the aforementioned verse, Surat an-Nisa` (6), where it was commanded to give the orphans’ share upon their rushd. That verse indicates that reaching bulugh is not enough for complete ahliyyat al adwa, thus making certain financial decisions only allowed after rushd (Çalış 2004, 110). Moreover, rushd seems to be a significant factor in assuming responsibility where greater social commitments are required (Muhammad et al. 2021).

2. B. 3. Adolescence in Traditional Islamic Thought

In this section, early Muslim scholars’ work as well as perspectives from Islamic tradition to adolescent psychology will be referred to. Some researchers state that a developing field called *Islamic psychology* is based on early Muslim scholars’ work such as al-Ghazali, Ibn Sina, al-Razi and al-Balkhi (York Al-Karam 2018). Among the traditional scholars, Ibn Miskawayh, Imam Al-Ghazali, Ibn Tufail and Ibn Sina’s views will be reviewed.

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*Islam and psychology* on the other hand is an interdisciplinary field that relates Islam to psychology in order to explore human being (Kaplick and Skinner 2017)
Ibn Miskawayh (d. 1030)

Ibn Miskawayh’s book *Tahdhib al-Ahlaq* (Refinement of Character) was monumental in Islamic history, having inspired many other scholars. In this book, he explores child development and education. His views regarding the soul are parallel to Plato’s writings in Republic. According to Ibn Miskawayh, there are three faculties of the soul: *al-quwwah al-shahwiyya* (the appetitive soul/soul of the animal), *al-quwwah al-ghadabiyyah* (the irascible soul/the soul of anger) and *al-quwwah al-natiqah* (the rational soul/soul of thought) (al-Din 1994, Zainuddin 2021). According to Ibn Miskawayh, the soul should be working in harmony with intellect and should not be leaning towards material things. He claims that the latter causes the person to be lost in material existence and lose centering, making the person unhappy (Durmuş 2001).

In his theory, the faculties of the soul develop in the human gradually. The first desire in children is nourishment; thus, they seek for the mother’s milk. The anger development follows, which will help the children defend themselves. Later, emotions and imagination develop to differentiate things. Following the development of discernment, the children start feeling shame. According to Ibn Miskawayh, one of the signs of the ‘rational soul’ is the appearance of ‘feeling shame’. (Altıntaş 2016; Güneş 2014). He also mentions certain signs that identify a young person reaching that stage where the rational soul is present, such as them lowering their gaze when looked at, their consciousness of avoiding wrongful actions and their inclination for the good (al-Din 1994). Ibn Miskawayh stated that those signs should be read as the young person’s readiness for formal education (Yilmaz 2017).

According to Ibn Miskawayh, almost all young people have the same behaviour-driving desires which is different than that differ from older people. He was once asked why people find it foolish when young people imitate elders, meaning if they act and talk more seriously and strictly, uninterested in things that young people desire. He answered:
When young men act like old men, they are signaling that their nature is not driven toward physical appetites, whose power and nature are at their fullest and sharpest extent during youth, when they are still developing. These appetites continue to increase to their maximal extent, and then they begin to decrease, following the pattern of all the powers of nature. So we know that a young man is lying when he claims the status of an old man in whom this power has declined, and we deem his lie and his inappropriate and unnecessary dissembling repugnant. (Al-Tawhīdī and Miskawayh 2019, 74-75).

He acknowledged that young men with such maturity can genuinely exist; however, they are rare, such as a saint or prophet. According to Ibn Miskawayh, in childhood and youth, desires and anger can overcome the intellect easier than older ages. He thought that older people’s desire and anger faculties are weaker, which explains their acting with more wisdom (Beheşti 2015).

Abu Ali Ibn Sīna (Avicenna) (d. 1037)

Ibn Sīna was an influential scholar in the Muslim world and known as ‘prince of physicians’ in the West (Chamsi-Pasha & Chamsi-Pasha 2014), particularly with his seminal book The Canon of the Medicine that had been a medical reference due to its strong content. In it, a section about child education (tarbiyya) includes children’s physical, moral and mental development and care (Tercan and Nurysheva 2021). According to him, child education stages should parallel child growth stages. His views regarding children’s cognitive development are similar to Piaget’s theory; however, the stages differ (Önder 2017).

Ibn Sīna’s developmental stages:

He suggested four main stages for child development: birth-3 years old, 3-5 years old, 6-14 years old, and above 14. He thinks that at 6-14 years old the child should have serious education that involves formal learning with other children (Akyüz 1982). He gave grave importance to formal education years since the young person’s skills and interests are shaped in that period. He thought that at the end of primary education the young person would either proceed learning a craft to get an occupation or continue
their education (Tercan and Nuryşsheva 2021; Önder 2017). According to Ibn Sina, a father could determine the readiness of their son for marriage upon observing their maturity, strength, and ability to live independently (Tercan and Nuryşsheva 2021). Ibn Sina had a great influence in his own time and centuries after.

Ibn Tufail (d. 1185)

He was an Andalusian scholar, philosopher and physician who worked at the Almohad Dynasty’s court (Baeshen 1986). He was inspired by Avicenna’s work and thoughts, as reflected in his writings. His famous philosophical novel titled Hayy ibn Yaqzan and also the two main characters of the novel Salaman and Abdal are taken directly from Avicenna (Davari 1980).

Hayy ibn Yaqzan tells the story of a child (Hayy) who grows up alone on a remote island. He navigates around the island with the help of a deer that eventually dies. Hayy’s development journey is described through his experiences. When he reaches the age of comprehending abstract concepts, he starts contemplating the world around him. One day Hayy sees another young boy like himself, and he learnt how to communicate with him in a short time. Hayy shares his thoughts with this boy named Abdal. When Hayy learns about another island with people in it, he wants to go and share his insights/thoughts regarding the truth; however, he realizes that not all people share the same level of intellectual receptiveness. In Hayy’s story, Ibn Tufail attempted to prove that humans can reach al-insan al kamil (the person who reaches perfection) by themselves through contemplation.

Ibn Tufail staged Hayy’s development by certain ages of significance: 1. from birth till seven, 2. twenty-one, 3. twenty-eight, 4. thirty-five, 5. forty-nine and above. In the first stage, Hayy is fed by the deer with milk and protected from outside harm. Later, he starts developing emotions and copying what he observes. For instance, he mimics his mother’s voice. When he turns seven, he starts feeling ‘shame’ and covers himself with leaves. The significant period in Hayy’s life is between ten and fifteen years of age upon the death of the deer and developing higher thinking skills. At that time, Hayy
starts questioning the source of life and death. When Hayy turns twenty-one, he is able to comprehend the source of life, body-soul relation, and answer other significant existential questions (İnce 2014). According to neuroscience (as explained in the next chapter), brain development is completed in the twenties, which means adolescents’ cognitive functions mature around this age. Tufail’s story from the 12th century is remarkable in terms of similarities with recent neurodevelopmental findings.

Abu Hamid Al Ghazali (d. 1111)

Al-Ghazali’s famous text *Ihya Ulum al-Din* (The Revival of Islamic Sciences) has a book called *Riyadatul Nafs* (Disciplining the Soul) in which a chapter called *Riyadatul Sibyan* (raising children) focuses on child development and education. In this chapter, developmental stages are explained from al-Ghazali’s perspective.

Al-Ghazali’s child development theory has similarities with Western theories since it also suggests a gradual process. Al-Ghazali bases that on the Quran: ‘We have created you in stages.’ (Surat an-Nuh, 14) (Kukkonen 2012). However, contrary to Western psychology theories, Al-Ghazali’s personality development theory starts before the child is born, when its parents choose to marry.

According to him, the infant starts comprehending through *al-ruh al-hassas* (‘sensible aspect of the spirit’). Al-Ghazali’s definition of this stage is like the sensory stage in Piaget’s cognitive development theory. The second stage is called *al-ruh al-khayali* where the imaginative part of the spirit facilitates learning. This part stores the sensible things and brings them to the intellect when needed.

The next stage of childhood begins at seven years and ends around fourteen. In that stage, the child starts differentiating good from evil (tamyiz, age of discernment). Al-Ghazali called that ability *nur al ‘aql* (light of the intellect) and recommended for the child to slowly move away from games and proceed with formal learning. He mentioned that *al-haya* (modesty) is also another sign of discernment.
The final stage comes around the ages of fourteen to twenty-one. In this stage, parents start being companions to their children instead of teachers as in previous stages (Arif 2018, 35-38).

Traditional Muslim scholars’ views are presented above. According to this review, the traditional Islamic approach involves the metaphysical aspect of understanding human psyche, which considers the ‘origin, nature and purpose of the human faculties’ in explaining ‘cognition’. However, Islamic cognitive theory (ICT) is not fully developed yet. The knowledge derived from Islamic tradition regarding the human cognition is not successfully articulated in current cognitive science terminology. Kaplick et al. (2019) talks about the future of Islamic cognitive theories and propose:

...in the long term, ICTs can emerge to constitute the interdisciplinary space where cognitive psychology, cognitive sciences, and cognitive and behavioral neuroscience engage academically with various Islamic sources, sciences, and/or schools of thought, predominantly in the context of Islamic metaphysics, advanced theology, epistemology, ethics, and cosmology. (73-74).

It is urgently needed for Islamic psychologists to focus on developmental psychology and particularly adolescence to understand that complex stage, and thus lead to developing more comprehensive frameworks in other disciplines that involve adolescents.

2.B. 4. Impediments to Ahliyya (awarid al ahliyya)

Physical or mental defects can affect ahliyya (legal competence) and restrict legal capacity. They can originate from natural or incidental reasons. Insanity, unconsciousness, mental derangement, and terminal illness are some of the natural defects. Incidental defects mentioned in Islamic law sources are intoxication (sakr), spendthrifts (safah), and bankruptcy (Zahraa 1996). Some resources categorize these impediments according to their origin being related to ‘free will’ or not. In this categorization, ‘minority (sighar), mental illness (or insanity: junun), dementia, forgetting (nisyan), unconsciousness (faintness: ighma), menstruation (hayd) and postpartum (nifas), slavery (riqq), and death (mawt)’ (Omar 2006, 37) are counted as
impediments that a human being’s free will does not play a role in, meaning they do not choose those actions. On the other hand, conditions such as ‘ignorance, being drunk and being a traveler’ are assumed as choices that are related to ‘free will’. In this categorization, certain conditions seem to affect ahliyya less than others. For instance, menstruation and postpartum are considered as a special condition for women and make them exempt from certain religious practices such as fasting; however, when the condition ends, they are obligated to make up their missed fasting. Scholars think these conditions differ from those affecting mental faculties; thus, the person still has the responsibility to make up their duties when their condition changes. Another example of having the mukallaf status despite changing conditions is travelling, where one’s being mukallaf is not cancelled and the person still has ahliyya. However, it is assumed that travelling includes some burdens that the mukallaf would suffer from in fulfilling their duties; thus, certain exceptions are made such as shortening of prayers (Kumah 2015).

Mental defects are significant conditions among those impediments in our study that affect ahliyya. It is essential to understand what makes them affect ahliyya since the adolescence period will be discussed in relation to mental capacity to make decisions regarding one’s own health. Junun or insanity seems central among the mental defects affecting one’s mukallaf status. Insanity can be defined as ‘loss of mental faculties and discernment to the extent of disabling a person from conducting his/her own affairs’ (Zahraa 1996, 252). Ash-Shafi’i (d. 820) uses the expression ‘one who has lost control of his mental faculties’ for an insane person (Immisch and Dols 1992, 9). Aql (intellect) is a requirement to be a mukallaf, and, according to Hanafi scholar as-Sarakhsi (d. 1090), in order to assume a person is ‘aqil (sane), that person should act like those people who are known to be ‘aqil, not say/do things against common sense, choose things that are good for this world and afterworld, and foresee the results of things they do/not do (Dal and Güman 2020, 774). He includes both majnun and ma’tuh in the insane category. Majnun refers to a person who cannot reason (‘adim al-‘aql) and ma’tuh (naqis al-‘aql) is the one whose reason is flawed.
Al-Kasani (d. 1191) added that insane persons become mukallaf again when they regain their clarity. However, he emphasizes that if the person does not seem fully competent, such as safih (spendthrifts), then they are considered as children (Immisch and Dols 1992). Scholars had differences of opinion regarding how to treat a safih person. Most of Hanafi, Maliki and Shafi’i scholars’ rulings for a spendthrift equate it to hajr, meaning ‘the judicial denial of the ability to dispose freely of one’s wealth’. In other words, a safih should not have the freedom to make financial decisions over their own wealth. However, Abu Hanifa rejected this view by the argument of ‘adamiyyah’, or human dignity in Islam (each human being having dignity that should be respected). According to Abu Hanifa, a sane adult should have the freedom to use their wealth however they like. Oussama (2000) thought that Abu Hanifa’s concerns for human dignity and freedom to choose one’s actions even when there is a concern of financial harm can be compared to the modern autonomy concept\(^5\) (300-303).

Al-Marghinani (d. 1197) mentioned another term among the impediments of ahliyya, called al-ghafla (imbecility). The Maliki school approaches the insane person as if it were a child, regardless if the insanity initiated from lack of reason (temporary or permanent). According to this school, a judge should decide if one is insane. Hanbali jurist Ibn Qudaama (d. 1223) thought that an insane person is deficient of reason, and it does not require great effort to recognize insanity in a person. (Immisch and Dols 1992).

Another temporary situation considered as insanity is dahsh, a state of shock, confusion, and disorientation where one loses judgment. The individual in that state is called madhush and is treated as insane in the Hanafi school during the period of confusion. (Grey et al. 2018).

In one incident, Prophet Muhammadﷺ emphasized the significance of mental faculties in judging one’s ahliyya or mukallaf status. Maiz bin Malik admitted he made zina (adultery). Prophet Muhammadﷺ asked his companions if he was mentally stable, and they confirmed he was. It was known that he did not have a mental illness;

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\(^5\) Autonomy term will be discussed in next chapter.

\(^6\) An Arabic phrase is used for Prophet Muhammad meaning ‘Peace be upon him’.
however, this question seemed to make sure that he did not have any mental challenge interfering with him comprehending the consequences of this action. Upon learning that Maiz did not have a mental challenge, he asked further to ensure Maiz was aware of what he committed. Once Maiz’s situational awareness was confirmed, then Prophet Muhammad ﷺ asked if he had any condition that temporarily affected his ahliyya, such as being drunk. After examining Maiz for those conditions, the judgment was made for his action (Dal and Güman 2020, 780).

2.C. Adolescent Profiles from Islamic History

Age was perceived as a significant factor in maturity in the pre-Islamic period of the Arabian Peninsula. Critical positions, particularly the leadership roles in society, were assigned to elders. They were assumed to have more experience due to the number of years they lived. Even Prophet Muhammad ﷺ’s age was an issue for the Quraish tribe when he claimed his prophethood. They did not think he had the experience necessary for religious leadership. However, in the early period of Islam, major roles were given to young members of the community. For instance, when Prophet Muhammad ﷺ asked for someone to help him in his new mission, his cousin Ali ibn Abu Talib volunteered. Prophet Muhammad ﷺ gave him the job of assisting him and told other people to obey him while Ali was only ten or eleven years old. It was an unimaginable situation for his people at that time. He also assigned Mu‘adh b. Jabal to Yemen and Hadramawt as a teacher and head of the messengers to Himyar tribe for donation and tax collection when he was eighteen years old. Adolescents such as Abd Allah ibn ‘Umar ibn al-Khaṭṭab, Rafi’ ibn Khadij, al-Bara’ ibn ‘Azib, Zayd ibn Thabit, Usayd ibn Žuhayr, and ‘Umayr ibn Abi Waqqaṣ participated in battles (Shuraydi 2014).

Imam Shafi‘i (767-820), after whom the Shafi‘i school of thought is named, had memorized the Quran at an early age (seven to nine). He was reported to have started giving fatawa\(^7\) when he was around fifteen or eighteen. Similarly, Imam al-Bukhari (810-

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\(^7\) Plural form of ‘fatwa’, a religious ruling which is issued by an authority according to Islamic law.
870) was sixteen years old when he went to Makka to do his pilgrimage, after which he stayed there six years to study (Seise 2019).

In some cases, adolescents were given principal responsibilities and roles due to their cognitive abilities that were relevant to the assigned task. For instance, Zayd ibn Thabit was assigned as interpreter and formal scribe while not yet 15 due to his talent with languages. Usamah Ibn Zaid was assigned as a general when he was sixteen to lead the army against the Romans⁸ (Al Fattani and Al Alem 2020). Muḥammad b. al-Qasim al Taqafi (d. 95/714) was praised in poems as the conqueror of Sind by leading the armies at the age of seventeen. Another Abbasid caliph Muʿtadid was mentioned as being in wars at the age of ten. Some people would predict which adolescents will become distinguished personalities based on the qualities they observe on them. For instance, a man in the community foresaw Muʿawiya being the leader of his people while observing him during childhood. (Shuraydi 2014). In the 10th century in Syria, Mariam al Asturlab was the daughter of an asturlab maker and became his student at a young age. She worked for the Sayf al-Dawla government (944-967) due to her advanced asturlab knowledge (Tokuş 2019 Woolf and Özdemir). Ibn Sina (Avicenna) presented remarkable intellectual capacity early on. He memorized the Quran when he was ten (Çağlar 2013) and studied medicine and philosophy, focusing on Aristotle’s works in his youth. He was only sixteen when he started working as doctor for the Emir of Khorasan (Tercan and Nuryşeva 2021).

Another reason for appointing young people to high positions was their interest and eagerness in learning and teaching the Quran. This was a valued quality since the early Islamic era (Shuraydi 2014).

In the Ottoman period, adolescents were treated as adults, making decisions on their own and presenting themselves at court. One example of this can be seen in court records of girls cancelling their parents’ marital arrangements. It was common for girls and boys to have been arranged to marry in childhood by their guardians. However, upon reaching puberty, they were able to go to court and cancel this arrangement. To

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apply for this process, they had to state they are baligh. Ten-year-old Ayşe’s and thirteen-year-old Habibe’s cases are examples of this situation. Ayşe and Habibe did not need anyone at court to talk on their behalf, both singly demanding to cancel their marriages (Araz 2012, 110). Children till adolescence were under the protection of guardians. However, once they reached adolescence, they were able to sue their guardians if they thought their rights were not duly protected. In one case, an adolescent Muhammed Agha sued his guardian uncle to get his money back, having claimed that the uncle used the money for himself (Dal 2021, 94)

Royal adolescents of the Ottoman Empire had to carry greater responsibilities. Sons of the emperors were called şehzade and were educated to be future emperors. When they turned twelve, they were sent away from the palace to practice governmental affairs. Fatih Sultan Mehmet was twelve years old when his father left the throne to him (Baykal 1956), reflecting the confidence of a father towards an adolescent son to govern a vast land.

There are discussions regarding whether these examples are unique adolescent profiles or if indeed adolescents were commonly given higher responsibilities in the early Islamic period. It is also possible that in our time adolescents are treated below their maturity level; thus, they are given fewer responsibilities than they could carry (Seise 2019).
CHAPTER 3

ADOLESCENCE IN PSYCHOLOGY

French historian Philippe Aries claimed that adolescence was conceptualized at the end of the eighteenth century. According to his view, before the eighteenth century, children would right away go into adulthood after their babyhood period finished. This view is criticized due to lacking evidence since Aries’s argument was mostly based on high-class families’ paintings (Smith 2017, 12-13). In the previous chapter, adolescent profiles from Islamic history showed that adolescence back then was perceived as an early adulthood where a person was assumed to have some capacities of an adult with certain exceptions.

Medieval historian Hanawalt thought that, during the Middle Ages, adolescents were controlled and manipulated by adults, which would cause tension between them. This tension can be observed in Shakespeare’s Winter’s Tale: “I wish there was no age between ten and twenty-three and youth spent those years in sleep instead of impregnating girls, cheating adults, stealing and fighting”. Similar perceptions of young people can be traced back to much older times in human history (Smith 2017, 12-13). Aristotle said: ‘the young are heated by Nature as drunken men by wine”. A 6000-year-old Egyptian writing on a tomb also mentioned young people not respecting elders and not having self-control.⁹

According to the World Health Organization (WHO), adolescence is a transition period from childhood to adulthood that includes the ages from 10 to 19 years old, which also indicates the reproductive stage in human life (Choudhury et al. 2006). The

word ‘adolescence’ comes from the Latin word *adolescere*, meaning ‘to grow up, to get mature’ (Dolgin 2014, 34). An American social psychologist Keniston suggests that adolescence is not just a ‘transition’ period (as cited in Demos & Demos 1969), but more like ‘having a temporary break on a trip to gain strength for the awaiting pain in the next part of the trip’ (637). Another metaphor used for adolescence is the cocoon stage from the metamorphosis of a butterfly, since a child goes through a drastic transformation to be an adult in this period (Nixon 2021; Plotkin 2008).

Adolescence psychologists define this period according to different observable features. G. Stanley Hall (as cited in Gander and Gardiner 2015, 438) referred to this stage as ‘sturm and drang’ (storm and stress); however, this view was later criticized due to not being confirmed by research. Schulz (as cited in Gander & Gardiner 2015) defined adolescence as a period in which a young individual is permitted to exercise the adulthood roles without having to face the consequences of citizenship obligations (438). Adolescence as a developmental stage was approached from different perspectives by psychologists. Freud made a grave emphasis on the sexual aspect of development while Erikson focused on its psychosocial dimension. In Freud’s five-stage psychosexual development theory (oral, anal, phallic, latent and genital stages), adolescence covers the fourth and fifth stages. While in the latent stage (6-12 years old) the child is uninterested in sexual drives, the genital stage (13-18 years old) represents an awakening in sexual interest. According to this theory, a sexual tension emerges in the genital stage that the individual needs to relieve. Freud thought that this tension can be fixed by finding an object to love, which leads adolescents to gravitate towards (usually) the other gender (Dolgin 2014).

Erikson defined eight stages in human development in his psychosocial development theory. Each stage has a normative crisis, meaning there is a task or difficulty that one must overcome in order to proceed to the next stage in a psychologically healthy state. In adolescence, Erikson thought the person has an identity or role confusion crisis. The adolescent either can develop an identity and continue to a healthy development or have role confusion where a developmental disadvantage
occurs (Smith 2017). Research shows positive correlation with identity crises and psychiatric disorders such as depression, anxiety, substance abuse and relationship issues (Gürsu 2011).

This stage has no certain time of beginning and ending; however, the second ten years of life generally cover adolescence. In modern times, since young people delay marriage or careers till the late twenties, adolescence is also extended. Adolescence experts divide this stage into three categories: early adolescence (10-13 years old), middle adolescence (14-17 years old) and late adolescence (18-22 years old). These years are roughly parallel to the school periods of middle school, high school and university. Each category has their distinct features. The beginning of adolescence starts with the physical changes contained within puberty. The word ‘puberty’ originates from another Latin word, pubertas, meaning adulthood (Steinberg 2017). The onset of puberty resembles an alarm clock, as the endocrine system gets activated to bridge the brain’s communication with sex glands. That ‘alarm clock’ role is believed to be played by different actors. One of them is a protein that is also responsible for obesity, known as leptin (Susman and Rogol 2004, 22-23). Changes in melatonin levels and body fat are also thought to be ‘permissive signals’ that allow puberty to start (Galván 2018, 226).

Puberty includes many physical indications such as increase in speed of growth, development of primary sexual features such as reproductive organs and testicles in boys and ovaries in girls, development of secondary sexual features that include changes in genital organs and breasts, hair growth on face, body and pubic areas. Furthermore, the body’s fat and muscle rations change in this period. Respiratory and circulatory systems go through changes as well to accommodate resistance and tolerance for exercises (Steinberg 2017).

The end of adolescence is not determined by concrete signs; however, different views are presented to indicate it. While some experts think that adolescence ends when physical maturity is reached, others think it ends when they reach the legal age of majority in which individuals can vote and get married. Another criterion to determine the end of adolescence depends on how the adolescent person is perceived in the social
context. According to that, adolescence ends when the ‘adolescent person’s decisions are respected, and others treat them as adults’ (Dolgin 2014, 35). This definition opens up new questions for our study. If the end of adolescence is decided when their decisions are respected, does that mean ‘adolescents’ decisions should not be respected till they are adults? Otherwise, this statement has to be discussed in detail in terms of which decisions adolescents can make and which ones they cannot. For instance, can they choose which school they want to attend? Can they refuse to receive lifesaving treatment? These questions will be argued in the next chapter.

Researchers pointed out the disparities between physical maturation and psychosocial maturation in this stage. Adolescent individuals seem to reach full physical maturity; however, they are not able to present a parallel maturity in their psychosocial abilities such as earning their own money or getting involved in adultlike social responsibilities (Wolman 1998).

2. A. Cognitive Development in Adolescence in Contemporary Psychology

Adolescents show more advanced cognitive skills comparing to children. They can think about the thinking process itself (meta cognition), which leads to a better self-awareness and building of self-identity. They can also comprehend abstract concepts and think about possibilities rather than limiting themselves only to reality. Steinberg (2017) explains this: for children, you are who you are based on their observations; However, for an adolescent, you are the single outcome of many possibilities of who you could have been (82).

Although different theories exist regarding cognitive development, Jean Piaget (1896-1980)’s cognitive development theory was a milestone in psychology (Barrouillet 2015). He built his theory based on his clinical observations, and it helped other psychologists to develop their theories to explain other dimensions of human development, such as Kohlberg’s moral development theory. However, in recent decades, there was a biologizing period in developmental psychology that led to
involving more neuroscience, behaviour genetics and epigenetics to understand adolescence cognitive development (Bjorklund 2018).

Piaget observed this period as a critical stage for logic development (Piaget 2008) and thought that cognitive development is based on brain and nervous system development as well as environmental factors through his clinical observations of children. According to his theory, four cognitive developmental stages exist in human life:

- Sensorimotor stage (0–2 years old);
- Preoperational stage (2–7 years old);
- Concrete operational stage (7–11 years old);
- Formal operational stage (11 years old through adulthood)

Over the first two years, children learn through their sensory system by touching, smelling, seeing, hearing and tasting. Between two and seven years old, they learn language and start using symbols; however, there is still no logical development observed in that stage. Around seven years old, their cognitive development allows them to start using their logic. For instance, they can understand that two different sizes of cups can have the same amount of liquid. Finally, around eleven years old, children start grasping abstract concepts and they can apply their logic towards making conclusions.

Piaget thought that people completely develop the necessary ‘hardware’ for decision-making during adolescence years. However, Commons, Richards & Kuhn (1982) criticized Piaget’s views suggesting that reasoning has more complex forms than ‘formal operational’ (1069). Donaldson (as cited in Gander and Gardiner 2015, 465) also criticized Piaget’s work claiming that children have more capacity than concluded in Piaget’s work. He thought that if the situations were presented in different ways in Piaget’s experiments, children would have responded differently.

Later research by Piaget’s followers performed in primitive cultures showed that not all individuals can reach the cognitive level that involves abstract thinking. It is more
common in industrial cultures; furthermore, education has a significant impact on developing abstract thinking (Gadner and Gardiner 2015).

One of the observed cognitive changes in adolescents is their noteworthy skills in arguments comparing to children. Parents think their adolescent children argue very often; however, this is the result of adolescents developing higher argumentative skills during this period. Adolescents do not accept others’ views without questioning. Demorest et al (as cited in Steinberg 2017, 87) also showed that adolescents understand sarcasm and teasing better than children.

3. B. Adolescence brain development and decision-making

Neurodevelopment studies indicate that the adolescent brain initiates neurobiological and hormonal changes responsible for emotional, cognitive, and behavioural growth observed in this stage. Some of the developmental neuroscience findings seem parallel to cognitive findings. For instance, in adolescence, the speed of processing increases, which is parallel to myelination (formation of a myelin sheath around neural axons) in the brain. The reason is that neural pathways are boosted when myelination increases. Another parallel is observed between adult-like expertise skills development and synaptic pruning (the brain eliminating extra synapses). Furthermore, development of the prefrontal cortex (PFC) system seems to go hand to hand with self-regulation development (Keating 2012, 275).

Limbic system changes during adolescence involve changes in the levels of dopamine and serotonin. Serotonin plays a significant role in emotional fluctuation during adolescence and leads to a depression-like behavioural syndrome (Garcia-Garcia et al 2017). Dopamine (DA) neurotransmission is responsible for many behaviours such as motor control, reward learning, decision-making, motivation, salience attribution and cognitive control (Reynolds & Flores 2021, 1; Jetha and Segolawitz 2012, 17).

Two major systems play a crucial role in decision-making: the cognitive-control system and socioemotional system. While the cognitive-control system involves
conscious, intended, willful and logical responses requiring time and effort, the socioemotional system (which consists of limbic and para limbic systems) involves automatic responses that are quick, not conscious, and stimulate changes in behaviour through emotions. These systems are significant in making a ‘good decision’. However, in adolescence, these systems are not fully developed. Their developing towards the fully mature brain starts in adolescence and goes into the twenties in both girls and boys. The brain maturation process happens from back to front, meaning the PFC is the last part to be fully developed, which is responsible for advanced reasoning, rational decision-making, planning, judging the results of actions, setting goals, metacognition and regulating emotions (Diekema 2020; Steinberg 2017).

Brain imaging of adolescent individuals presents the change in brain regions that are also related to reward sensitivity and behaviour control, which is thought to be the reason for the peak in adolescence risk-taking between 15-17 years of age. (Peeters et al. 2017). Risk-taking in adolescence is a critical concept for our study since it affects the decision-making mechanism. No consensus exists in psychology and neuroscience regarding what the risk-taking concept really is and if risk-taking is a disadvantage altogether or not. Some studies differentiate negative risk-taking from the positive one. For instance, having unprotected sex, riding a car without a seatbelt, stealing and cheating are among the negative examples (Duell et al. 2022). Suicides, accidents (and ensuing injuries) and homicides make up more than seventy percent of adolescent deaths (Bonifacio 2010). However, trying a new outfit or hairstyle, befriending someone new and taking a new course are among the positive risks that could be advantageous to development and socially acceptable (Duell et al. 2022).

Another discussion regarding risk-taking behaviour of adolescents is about how they perceive the risk and comprehend the consequences of that behaviour. Despite the misconception about adolescents’ risk evaluation and perception being impulsive and irrational, the studies showed no difference between adolescents’ and adults’ evaluation of risks and their consequences. Thus, there must be other explanations to explain the peak in risk-taking in adolescence. Two possible reasons are suggested. First,
some reward value in the risk behaviour can be bigger for adolescents than for adults (Peteers et al. 2017). Greater reward value can result from adolescents’ still being in the process of building their self-identity. For instance, gaining or maintaining social status can matter more for an adolescent and thus lead to risk-taking behaviour in low- or high-status individuals (Andrews et al. 2020) Second, adolescents can generally be more sensitive to rewards than adults. Brain imaging confirms that adolescents’ brain systems get more activity in reward-related areas when doing risky tasks (Peteers et al. 2017).

Texting while driving is one of those risky behaviours that demonstrates how the possible risk-reward calculations work in adolescence. Rosenbaum & Hartley (2018) schematized the factors affecting decision-making in a situation where the person must decide about checking a text (fig2). They thought that a teenager would have an idea of the risks and benefits or checking a text based on knowledge they have or from personal experience. For instance, they might have listened to the dangers of distracted driving or seen many people texting and not causing an accident. They weigh the risks and rewards using personal experiences or such knowledge gained from the social environment. The reward of checking a text while driving for a teenager would be getting exciting news or a message from a person they like. Rosenbaum & Hartley suggested that, in adolescence, the immediate reward of checking the message wins over the delayed reward of arriving home safely. Moreover, the likelihood of consequences influences a teenager’s decision-making. For instance, checking the message will be most likely rewarding; however, getting into a car crash because of checking a text message is a much smaller possibility (3-4).
Figure 1: A schematic representing a common naturalistic choice and highlighting contextual features that may differentially influence choice across development. (Rosenbaum & Hartley 2018, 3).

Some researchers criticized the generalizations regarding the adolescent brain not fully maturing till the twenties, and their judgment and decision-making being limited till that age based on the findings that PFC development continues till adulthood. According to these generalizations, the adolescent brain is inferred to be disadvantageous in decision-making. However, Romer et al. (2017) claimed that, since adolescence is a developmental period, the changes in the brain should ideally evolve to serve their adaptation. For instance, pruning in the brain is different in individuals with
different socioeconomic statuses since their environmental needs are not the same. Their adaptation mechanisms to different environments would function accordingly. They criticize researchers’ focusing on maladaptive behaviours such as drug use, pregnancy, and other unhealthy risky behaviours rather than focusing on environmental variables. They stated, despite adolescents in that stage being pictured as ‘impulsive, emotional and distraught’, that most adolescents pass this stage without using drugs, getting pregnant or similar risky behaviours. Thus, they concluded that adolescent risk-taking is needed for adaptation to gain experience and is beneficial for learning adult behaviours (19-20; 30). Moreover, if the adolescent maladaptive behaviour is determined to have resulted from the brain maturity difference compared to the adult brain, then children would be expected to engage in even more risk-taking since they cannot foresee the results due to their less-developed brain structure.

Others who also thought that the adolescent brain serves an adaptational purpose claimed that suboptimal behaviours help increase genetic diversity since the person takes risks by leaving home. It is significant that risk-taking and sexual maturity feature around the same time in adolescence development. Another adaptive advantage of suboptimal behaviours (despite the risk of some negative outcomes such as injuries, addictions, etc.) is that they help adolescents improve their independence skills (Bonifacio 2010).

Casey et al. (2008) suggested a model to explain the developmental differences of the adolescent brain from that of the child or adult. According to this model, adolescence decision-making cannot be solely explained by the immaturity of the PFC. In Figure 2, A graph shows the traditional understanding that suggests adolescents make poor decisions due to PFC immaturity.
Figure 2: The traditional explanation of adolescent behaviour has been suggested to be due to the protracted development of the prefrontal cortex (A). This model takes into consideration the development of the prefrontal cortex together with subcortical limbic regions (e.g., nucleus accumbens) that have been implicated in risky choices and actions (B) (Casey et al 2018, 14).

However, Casey et al (2008) suggested that limbic and subcortical systems have to be taken into account together with the PFC in decision-making (graph B). Limbic and subcortical systems control impulsivity and develop earlier than the PFC, which is responsible for risk-taking. In adulthood, both systems are fully developed; however, in childhood, both systems are underdeveloped. In adolescence, there is an imbalance where the limbic and subcortical systems are mature while the PFC is lagging. They thought that adolescents are able to reason and comprehend potential risks of their behaviour and choices. However, during an ‘emotionally salient’ situation, their limbic control system overrides the PFC since the former is more mature at that period (63-64).

A recent longitudinal study of 335 adolescents to investigate ‘the effects of sex difference on the limbic system and its outcomes’ showed that the volumes of the amygdala and hippocampus increase in boys and decrease in girls in adolescence. This leads to increased positive emotional regulation in boys and decreased positive emotional regulation in girls:
... sex differences on *emotional regulation* as measured by positive personality traits and this effect was related to the maturation of regions of the limbic system. The sex effects on the adolescents’ “positive characteristics” changes, that are a subscale of the positive personality traits scale, were identified to be mediated by the hippocampus and amygdala maturation. Positive attributes are meant to gather (1) positive character items (e.g. how the adolescent feels generous, affectionate, caring, social, easy-going) and (2) positive action items (e.g. how the adolescent is proud to be good at sport, well behaved, polite, helpful at home). Globally, they are positively and closely related to current levels of adolescent’s well-being (Frere et. al. 2020, 8).

Overall, the adolescent brain is significantly different than child and adult brains, and that seems to affect the processing of risks and rewards, self-regulating and being affected by peers in decision-making. Thus, all these factors also affect medical decision-making (Grootens-Wiegers et al. 2017).

Adolescence in mainstream psychology was reviewed in this section.

>Adolescence decision-making in the Canadian context will be reviewed in the next chapter.
CHAPTER 4

Adolescent Medical Decision-Making in Canada

Medical decision-making is a relatively new term in bioethics since, starting from the Hippocratic period up until the end of the 19th century (Faden et al. 1986), ethics in medicine had been previously based on the beneficence principle. This principle gave the physician full authority to decide on the patient’s behalf; this also included the principle of benevolent deception. Upon the Enlightenment period in Europe, and the introduction of new ideas in philosophy and regulations in law (Will, 2011), patient autonomy was introduced into medical ethics. First, a patient’s informed consent was required for medical treatments; later, shared decision mechanisms developed; this meant that the burden of making a decision was shared between the patient and the physician (Childress and Childress, 2020). As will be discussed in the next chapter, autonomy and informed consent were well-known ethical principles from much of the early Islamic period.

Medical decision-making refers to standards in making ideal decisions in the medical context. It aims to articulate how medical care workers and patients make decisions. Moreover, it refers to determining challenges and the necessary elements of optimal decision-making. It also proposes to develop tools and guidelines for health care workers, patients, and policy makers in order to make good decisions in a clinical context (Schwartz and Bergus 2008). Another definition refers to medical decision-making as a process for deciding on a diagnosis or treatment plan that can be made based on the available data and consideration of the patient’s expressed inclination (Whang 2013).

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10 Physician’s hiding information from the patient to protect the patient from possible negative emotional effects of learning the diagnosis.
Overall, the term is used both to refer to the physician’s choice of a certain
treatment plan (a preventative intervention if needed) and making a decision while
involving the patient in the process. In this study, the decisions that medical workers
make (the calculations of benefit and harm of the treatment methods) is out of scope.
Instead, decision-making mechanisms involving a patient will be explored in depth for
the purpose of our research.

Making decisions to accept, deny, or select among multiple medical treatments,
or participating in research, becomes more complicated when the patient does not have
the competence to do so on their own, such as may be the case with the mentally
challenged, handicapped, intoxicated or those otherwise impaired. Children are
included in this group too; thus, a surrogate or substitute decision-maker, which is
usually a parent or guardian, is required to cooperate with physicians to decide in the
best interest of the patient (Harrison 2004). However, when children reach adolescence,
different views are presented regarding their capacity for decision-making (Diekema
2020).

In this chapter, first, adolescence medical decision-making will be explored by
investigating the significant components of this issue, such as competence, capacity and
autonomy of adolescents. Secondly, medical decision-making concepts, applications and
legal regulations will be discussed in the Canadian context.

4. A. Adolescent Decision-Making in the Medical Context

The unique nature of adolescence compared to childhood and adulthood from a
developmental aspect is the main reason for the complexity of ‘adolescence decision-
making’ in a clinical context. The decision-making process itself (even without taking
adolescence into account) is not easy and cannot be treated with a one-size-fits-all
approach. Making decisions regarding medical situations whether agreeing on a
treatment or participating in medical research requires careful prioritization of several
factors. Thus, in this section, different approaches to medical decision-making
mechanisms will be explored briefly, followed by an in-depth investigation of adolescent medical decision-making.

5. A. 1. Approaches to Medical (Clinical) Decision-Making

Medical decision-making approaches vary depending on the involvement of the patient, physician/health-care team or surrogate decision makers in the decision-making mechanism. As mentioned in the introduction to this chapter, clinical practice was more paternalistic at the beginning, focusing on the illness and how to treat it rather than considering the patient as a whole (de Haes 2006). The doctor had the full authority to decide on the patient’s behalf. Although for many years this approach served to make clinical decisions, starting from the 1950s, the perception towards that approach has changed (Killbride & Joffe 2020). Around the 1980s, decision-making mechanisms progressed to give more autonomy to patients since the doctor-centered approach was thought to be neglecting the patients’ personal experience with the illness and their involvement in the decision. (de Haes 2006). Doctors had to give up their full authority to make the medical decisions; however, they still held their position of authority in the field due to their knowledge and access to resources (Killbride & Joffe 2020).

Autonomy is a significant concept in discussing decision-making mechanisms in our time. The term autonomy originated from the Greek ‘self-governing’, autos (self) and nomos (law). Piaget defined it as “being subject to one’s own rule” (Kağıtçibaşı 2013). According to the American Psychology Association (APA), autonomy is ‘a state of independence and self-determination in an individual, a group, or a society’. Autonomy can also refer to “individuals’ desires for and control over personal issues, or matters pertaining to privacy and individual prerogatives”. Among the personal issues, decisions regarding one’s own body, privacy, self-expression, communication, and affiliations can be listed. Self-expression choices include those regarding their outfits, designing their own space and time. Communication choices involve the person’s transmissions via all communication tools such as phone and electronic mails. A person’s choice of affiliation
refers to relationships with friends or partners. According to this view, all these choices should be in the realm of autonomy and (ideally) should not be directed by others since they are related to an individual’s ‘self’ (Smetana 2017, 54).

In the clinical context, upon the acceptance of the autonomy concept as a significant factor in decision-making, the patient-centeredness approach became widespread in recent years. Patient-centeredness is a psycho-social model that considers patients’ psychological and social needs along with their medical needs, contrary to the purely biomedical doctor-centered approach. Shared decision-making is one of the patient-centered mechanisms that is based on the patient and the physician deciding together as relevant. Even though patient-centered methods are idealized, research shows that the assumption of every patient preferring to get involved in the decision mechanism is not always the case. Some patients do not prefer to be informed nor become involved in their health decisions, rather leaving it to the physician (de Haes 2006, 291-294). Decision-making in a critical medical situation can be overwhelming, even a burden for the patient (Davies & Parker 2022).

Some studies show that patient-centeredness is not always as effective as expected in practice (de Haes 2006, 291-294). Killbride & Joffe (2020) observe that, in the digital age, doctors’ strong authority in medical knowledge was affected since patients can gain knowledge from the Internet. In some rare diseases, patients end up learning more than their doctors through their online search (2).

Patients’ involvement in decision-making required them to be informed about the illness, treatment method, and pros and cons of an intervention. Thus, according to Faden et al. (1986), informed consent is vital for the shared decision-making which refers to ‘autonomous authorization by a patient or subject’ (274). According to Manson & O’Neill (2007)’s definition:

The informed consent procedures now used in biomedicine require certain agents (researchers; clinicians; genetic counsellors, etc.) to disclose information about certain things (proposed research; proposed medical treatments; costs; benefits; risks; alternatives) to certain others (potential research subjects; patients; those deciding whether to proceed with genetic testing) (27).
Informed consent has five elements: disclosure, comprehension, voluntariness, competence and decision-making (or consent). Ideally, informed consent should include a clear, comprehensive ‘disclosure’ regarding the intervention, the patient should understand it, should not be under any undue influence and should have the competence to make that decision. (Faden et al. 1986, 274).

3. A. 2. Adolescents’ capacity in medical decision-making

Medical decision-making includes a wide variety of health decisions including serious ones such as end-of-life. When adolescents are the patients, the whole decision-making mechanism must be reconsidered according to their developmental features. For instance, informed consent requires competence to decide and comprehension of the disclosure. However, children and adolescents are considered as not having the competence to make medical decisions unless they prove otherwise (Diekema 2020).

In clinical ethics, a minor’s agreeing on an intervention/research participation is differentiated from ‘informed consent’. A minor’s approval for an intervention or participation in research is called assent and this term is used for minors as an alternative to informed consent. A minor’s refusal of an intervention or participation in research is called dissent (Al-Sheyab 2019). These concepts were added to literature in the late 20th century. The American Academy of Pediatrics (AAP) published a statement in 1976 that suggested that the term ‘informed consent’ cannot be used for children since they cannot legally give consent. AAP also added that parents should not be the only decision-makers in children’s healthcare. Thus, they suggested: 1) using assent instead of informed consent for minors, and 2) the treatment decision should be made by combining child’s assent and parental permission. For giving assent, a child should have these qualities according to AAP:

(a) knowing what procedures will occur, (b) choosing to participate out of free will, (c) clearly communicating this choice, and (d) having awareness of the ability to withdraw from participation (Brown et al. 2017, 652)
Competence is one of the key concepts at the core of adolescents’ involvement in their health care decisions. In the legal context, competence refers to ‘the right to give an opinion (e.g., assent to a procedure) or to make an autonomous decision (e.g., benefitting from confidentiality and consent for an intervention or a treatment)’. However, in the clinical context, it means ‘the cognitive and psychological capacity to make autonomous decisions’ (Michaud et al. 2015, 362; Hein et al. 2015). Competence is required in adolescents’ decision-making in clinical care to respect their autonomy while protecting their vulnerability. Both in legal and clinical care contexts, no universal consensus exists regarding determination of adolescents’ competence (Grootens-Wiegers et al. 2017). However, many attempts were made to help health care teams in judging those cases.

The Gillick Competence Test is one of the methods to measure competence that originated from a court decision (Gillick v West Norfolk and Wisbech AHA, 1986) in the United Kingdom where the House of Lords decided in favour of children under sixteen giving consent for immunization, medical examination, and treatment if they present the intellectual capacity, maturity and comprehension of the subject. The decision came after a mother’s objection to Department of Health for their policy regarding a doctor’s prescribing contraceptives to children under 16. In the example of immunization, to prove the child has competence to make decisions, they should exhibit the comprehension for the “necessity of immunization and the reasons for it; and the risks, intended benefits and outcomes of the proposed immunization and alternatives to immunization, including the option of not having or delaying the immunization” (Griffith 2016, 244-245).

Maturity and intelligence are the core factors that the Gillick competence test aims to investigate. To make conclusions regarding a child’s maturity, the person who applies the Gillick test must judge the capability of the child in governing different factors during their decision-making such as their anxiety, as well as family or peer influences on them. A child’s intelligence in this test involves their understanding of

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11 The decision can be read here: https://www.bailii.org/uk/cases/UKHL/1985/7.html
long-term consequences of their decision on their life (such as family and school) and their capability of evaluating the relevant benefit and harm of the intervention.

Depending on the seriousness of the medical decision to be made, different levels of maturity and intelligence can be required (Griffith 2016).

The Gillick competence test is used for ascertaining the competency of children and adolescents, allowing them to make autonomous decisions if they can pass it. In bioethics, respecting autonomy and non-maleficence are among the main principles. When an adolescent person is involved in deciding on a risky medical intervention, proper prioritization of these principles becomes crucial since respecting their autonomy should not be at the cost of their health. Hunter and Pierscionek (2007) point out that using the Gillick test for competence in research participation has greater risks, particularly if the researcher is the one who applies the test. Unlike medical interventions, a researcher’s personal interest and possible benefits from the research create a conflict of interest. The preceding authors suggest that someone outside of the research should apply the test for objectivity. According to them, the test can be applied on adolescents in a research context under two conditions: 1. If the potential benefits of the research for the participant are noteworthy while the risks are insignificant, and 2. if it has potential social benefits and involves negligible risk for the participant despite parents not approving (660-662).

During the COVID-19 pandemic, the Gillick test was used as a criterion in the UK (Griffith 2021) and Australia (Massie et al. 2022) to conclude whether adolescents were competent in deciding to get themselves vaccinated. In the UK, 12–15-year-old adolescents were able to override their parents’ decision of not vaccinating them if they were able to pass the Gillick test. However, if the same age group of children opposed vaccination despite their parents’ or legal guardians’ consent, they would still be vaccinated even if they passed the Gillick test. Thus, the test was used only to accommodate the children/adolescents whose parents/guardians prevented them from...
getting vaccinated - a treatment assumed by officials to be in the child’s benefit (Griffith 2021). Similarly, if the child refused to get lifesaving treatment, their decision could have been overridden by parents’ consent or court’s power in the UK (Cave 2014, 106).

That presents an asymmetry in minors’ decision-making since they could only consent to decisions medically beneficial for them. Adolescents are not provided the same rights as adults since the latter can refuse treatment that is suggested as being in the ‘best interest’ for their health. However, adolescents can only assent to treatment (Parker 2011). The asymmetry regarding allowing competent adolescents to assent to treatments/vaccinations while not allowing them to refuse (dissent) is defended by ‘transitional paternalism’. Tucker (2016) thought that three reasons make transitional paternalism necessary in the clinical context when adolescents are present:

First, the asymmetric version of transitional paternalism takes seriously duties to support adolescents’ developing autonomy, alongside other duties that adults have to young people. It does so by enabling young people to be involved in important decisions that they would otherwise be excluded from. This is of value because participation of this sort is central to the cultivation of their self-governance. Second, only the asymmetric version gives young people a voice in respect of all clinical actions, and only the asymmetric version leaves open the possibility that the coarse lines of legislation might be ‘fine-tuned’ in individual cases. Third, the asymmetric sharing of normative powers is consistent with the kind of social arrangements that best support autonomy (759).

Cave (2014) criticized the Gillick test for not being applicable in all medical decision situations since it was originally developed to solve a specific case. Moreover, the author found the later cases of judicial interpretations problematic, presenting ambiguities regarding the application and timing of the test (105-107).

In the US, some courts require a psychological consultation to judge adolescents’ capacity and competence. For this purpose, one recent study investigated psychological maturity and cognitive capacity of adolescents, similar to the aim of the Gillick test. Cognitive capacity refers to logical thinking; psychological maturity is “individuals’ ability to restrain themselves in the face of emotional, exciting, or risky stimuli”. The study was conducted on 5,277 individuals from 11 countries. Cognitive capacity seemed to reach
the adult level around age 16 while psychosocial maturity is fully developed around age 18. As previously reviewed, brain development during this period creates a ‘maturity gap’ where the adolescent individual can be 16 and make adult-like deliberate decisions; however, the same adolescent can make ‘immature’ decisions when the situation is emotionally tense. Researchers in this study suggest a different age range be set according to the legal context, depending on if it requires either cognitive capacity or psychological maturity (Icenogle et al. 2019).

Same-age adolescents can show different levels of competence depending on their individual developmental journey. Michaud et al. (2015) emphasized cognitive development speed variances in adolescence, dampening the determination potential for decision-making capacity (363). Adolescents’ PFC development not being completed as well as emotional factors affect the way they perceive medical situations. Their reasoning process can be either ‘analytic’ or ‘heuristic’ depending on the involvement of emotions. Some experts call these modes of reasoning ‘hot cognition’ and ‘cold cognition’. According to this categorization, hot cognition refers to decisions made under elevated emotional arousal, while cold cognition indicates decisions made without emotional stress. For instance, having parents present in medical deliberations can be a factor in emotional stress due to opposing views (Michaud et al. 2015).

Another factor crucial in adolescents’ navigations of medical choices is ‘autonomy’. As earlier mentioned, it is desirable that a person should have the capacity to decide autonomously on their own healthcare. Thus, its development in an adolescent is crucial for one to grow as a healthy individual. According to the separation-individuation process theory, the first stage of autonomy development is completed when the children can differentiate themselves from their caregiver. Adolescence is the second stage of the separation-individuation process where the adolescent person would be ‘shedding family dependencies’ to gain ego maturity and a strong sense of self, and support themselves (Kroger 1998, 172-175).

Kağıtçibaşı (2013) criticized autonomy theories where its development is based on distancing the self from others, being separate and unique. She found this approach
individualistic, that it implies that a person’s connectedness with others would make them less autonomous. According to Kağıtçıbaşı, contrary to autonomy theories, relatedness with others does not prevent one from being autonomous. She indicated that both autonomy and relatedness are basic human needs (223-224).

A healthy development of autonomy during adolescence depends on several factors such as parent-child interactions, peer relations, and cultural expectations. A reciprocal parent-child relationship is vital, as are adolescents’ freedom of expressing their opinions and being tolerated when they think differently (Smetana 2017).

An adolescent can develop a ‘healthy’ autonomy; however, to ensure they make autonomous decisions, they should act intentionally, understand their actions and consequences, and resist outside influences. Otherwise, even if a person has ‘autonomy’, it is difficult to call their action ‘autonomous’ if it misses one of these criteria (Faden et al. 1986).

The World Health Organization (WHO) provided a framework regarding assessing adolescents’ capacity to make autonomous decisions. Although legal regulations differ in each country, this framework is suggested as a general guideline to point out significant aspects of making medical decisions with adolescents (fig4).
Figure 3: ‘Practical steps for assessing and supporting adolescents’ capacity for autonomous decision-making’ (Baltac et al. 2022, 13).

4. B. Legal Regulations Regarding Adolescent Medical Decision-Making in Canada

Most countries accept an 18-year-old adolescent as competent, and thus have set this as the age of majority. Exceptions to this rule exist, such as in cases involving those with mental health or intellectual disabilities (Michaud et al. 2015, 362). In some countries, even young children can be considered competent depending on the situation and approval of healthcare teams. In the US, a 7-year-old can assent (agree) to medical treatment (Grootens-Wiegers et al. 2017). Some countries require legal workers to participate in judging competence.

In Western Europe, competence of a child or adolescent is assessed by clinical workers and/or a healthcare team (Michaud et al. 2015, 362). Research participation decisions are also regulated in European Union countries. The Second Directive by the European Parliament and the Council of the European Union has this statement: “A clinical trial on minors may be undertaken only if the minor has received information according to its capacity of understanding” (Grootens-Wiegers et al. 2017). Sénécal et al. (2016) summarized the legal approaches in the EU and Canada regarding when a minor can make a health decision in three categories:

(i) consent by minors for healthcare decisions from a fixed age onwards;
(ii) Competence-assessment-based consent;
(iii) a mixed approach where fixed age limits are combined with competence-based approaches (1560).

The fixed-age approach has different applications in European countries. In the Netherlands, children 12 and up can get involved in research or make treatment decisions together with their parents, and those 16 and up can make their treatment decisions alone. In the UK, children can receive treatment without parental consent.
under 16 if they are able to pass the Gillick maturity measurement test (Grootens-Wiegers et al. 2017).

In France and Greece, legal capacity to consent to medical decisions matches the age of majority. Prior to that, the decision is made by parents with the minor’s assent if they can understand and articulate their reasoning. Dutch law allows minors aged 16+ to consent to treatment by themselves if it is beneficial for them and involves legal actions regarding their decision.

In Bulgaria and Poland, dual consent is required for medical interventions - one from the child and one from the parent or legal guardian. In Bulgaria, dual consent is required for minors between 14 and 18; in Poland, with minors older than 16. In Spain, a 16-year-old person can give consent unless they are intellectually or emotionally not capable of understanding the purpose and possible consequences of the intervention. However, starting from 12 years old, adolescents’ opinions are taken into account while making medical decisions (Sénécal et al. 2017).

In Canada, minors’ medical-context decision-making is a complicated issue. There are three mechanisms in Canadian legislation regarding their making treatment-related or other medical intervention decisions. The first one is common law where the mature minor concept features significantly. Normally, parents are the decision makers for minors; however, according to the mature minor doctrine, children/adolescents may be able to make their own medical decisions. The second one is provincial (and territorial) legislation in which the minors’ consent for medical interventions is regulated. Depending on the province, either fixed-age legislation or competence-based approaches are applied. The third one is child protection legislation. These three mechanisms determine how parents, children and health care workers will be involved in minors’ health-related decisions. These regulations also enable child protection agencies to apply to a court when the minor or parent refuse treatment (Bala & Houston 2015).

Adolescents are not a homogeneous group; thus, if there is no fixed age for consent, a child’s ability to act autonomously is judged case-by-case (Flyn et al. 2014).
Québec is an example of the fixed-age method where 14-year-olds and above can give medical consent (Schwartz et al. 2018). If they are required to stay in a health care or social services facility more than 12 hours, their parent or legal guardian must be informed; otherwise, they are not required to be informed even regarding their medical decisions (Sénécal et al. 2016).

Rozovsky (2003) stated in her book Consent to Treatment: A Practical Guide that the rights of minors in Canada started with the discussions of the emancipated minor concept, which later evolved into the mature minor doctrine (cited in Bonifacio 2010). Emancipation in this context refers to children being considered as adults before they reach 18 under certain circumstances. It is also a common concept in the US; however, in Canada it is only applied in Quebec. Two types of emancipation exist there: simple and full. In simple emancipation, their parents cannot have custody nor make decisions for their children. Emancipated children can sign contracts and defend their rights. In order to get simple emancipation, a teenager can either file a declaration with the Public Curator or ask the court for emancipation.

Full emancipation includes more rights, such as making a will, suing parents for support, signing a lease, buying or renting, getting a driver’s licence and taking out a mortgage. There are a few exceptions that differentiate an emancipated teenager from an adult. For instance, they cannot vote, buy cigarettes or go to bar/casinos. When they are involved in a crime, they also go through a different trial process than adults (Éducaloi 2023).

One of the first case examples of ‘emancipation’ in Canada was from Toronto; however, the word ‘emancipated’ was not used as a term at that time. It was a case of a nineteen-year-old and his father against a hospital (Booth v. Toronto General Hospital, 1910) where the father and son sued the hospital following the complications of a nose surgery. The child had permanent disability after the surgery, and they accused the surgeon of not asking parental consent for the procedure. However, the Ontario Superior Court under Falconbridge CJKB indicated that parental consent would not matter in that case, and the child’s consent would be enough since he worked ten hours
a day as an employee. That was shown as an indicator that the child was able to take care of himself; thus, he could consent for himself (Bonifacio 2010; Ferguson 2004).

In 1991, The Convention on the Rights of the Child (CRC) was accepted by Canada, which had an impact on Canadian legislation and common law. One of the most significant rights in CRC is children’s right to participate. Article 12 acknowledges children’s capability of expressing their opinions regarding matters of tangible effect on them. In the Article 12, children’s right to be heard is protected whether the child represents themselves or a representative speaks for them. Article 12 is particularly critical due to including children in decision-making processes that affect their lives directly (Bala & Houston 2015). In it, it was underlined:

...maturity refers to the capacity of a child to express views on issues in a reasonable and independent manner. Maturity must also be assessed according to the matter at issue: the greater the impact a decision will have on a child’s life, the more relevant the assessment of maturity becomes.

Decisions regarding health care can affect a child’s entire life, which is why their opinion is significant according to this legislation. Canadian provinces differ in applying the maturity of the child into legislation. In New Brunswick, the Medical Consent of Minors Act regulates the self-titled topic. According to this act, children who are 16 years and older can consent for themselves. For children under 16, Section 3(1) says:

The consent to medical treatment of a minor who has not attained the age of sixteen years is as effective as it would be if he had attained the age of majority where, in the opinion of a legally qualified medical practitioner, dentist, nurse practitioner or nurse attending the minor,

a. the minor is capable of understanding the nature and consequences of a medical treatment, and
b. the medical treatment and the procedure to be used is in the best interests of the minor and his continuing health and well-being.

As it can be seen in this section, according to this act, maturity itself is not enough for a minor to consent; the treatment should be beneficial for the child and a medical practitioner has to approve it being in the child’s best interest. British Columbia’s Infant Act is very similar to the New Brunswick one; however, it does not
specify age. In Alberta, the child can give a health directive at the age of 18, and in Saskatchewan at 16. If there is no application by a child protection agency to make a treatment decision for the child, then the common law’s mature minor doctrine would be used. In Ontario, Yukon, and Prince Edward Island, children can consent to treatment just like anyone else; age is not part of the regulation. However, if a child (or adult) cannot comprehend the information to make the treatment decision, then this rule is not valid. In Newfoundland and Manitoba, the age of consent is 16; however, if children under 16 prove their capacity, they can consent for treatment as well (Justice Laws Article 12 Part III).

Reviewing the regulations in Canadian law shows that health care professionals’ (HCPs’) involvement in medical decision-making is crucial. When a minor’s health decision must be made, HCPs are in the position to judge the situation from a medical perspective to weigh the benefits and harms facing the patient to decide for the patient’s ‘best interest’. Moreover, HCPs are also charged with judging the ‘capacity of the minor’ for giving consent for treatment if there is no fixed age regulation in the legislation of their province or as specific cases require. Thus, when an HCP is asked by a minor for their medical decision to be respected, they have to act according to ‘provincial health care’ and ‘consent’ legislation they abide by.

Ferguson (2004) categorizes the models that HCP workers are supposed to use in Canada: 1) ‘best interest’ models, 2) capacity-based models, and 3) no health care/consent legislation model. British Columbia and New Brunswick emphasize the best interest of the child, although they use age-based presumption of capacity as well. Ontario and Prince Edward Island do not specify any age for consent; however, they underline that any minor who espouses capability of medical decisions can give consent. Manitoba, Newfoundland and Labrador, Saskatchewan, Alberta, and Nova Scotia are listed among the provinces that did not specify the criteria for judging the entitlement of the minor to decide on their health. However, age-based regulations exist in Manitoba, Newfoundland and Labrador, Saskatchewan, and Alberta. According to Ferguson, these models are not sufficient to guide HCPs in adolescents’ medical
decision-making. First of all, there is no consensus among these regulations to guide HCPs, especially around making decisions in conflicted situations. Secondly, concepts such as ‘best interest’ or ‘consent’ that are critical to decision-making are not clearly defined in the legislation. Ferguson (2004) states:

Are a minor’s “best interests” being pursued, for example, if the proposed treatment would leave her physically well, but feeling spiritually violated? Does “consent” include refusal of treatment? That only some provinces feel it necessary to employ an age-based rule (rather than an age-based presumption, or capacity-oriented rule) suggests that such continued use of age-based rules may now be more a matter of policy than of administrative shorthand for capacity (11).

Ferguson also argues that age-based regulations which are grounded in minors’ development are problematic for three reasons: 1) difficulty of categorizing minors by age according to their psychological development; 2) mature decision-making can develop at different ages in each minor; and 3) the definition of a mature decision is ambiguous; minors with the required skills can make mature health care decisions (79).

4.B. 1. Adolescent Confidentiality

Although confidentiality and consent are related terms, they refer to separate concepts. Consent legislation deals with decision-making capacity; however, confidentiality concerns itself with securing the privacy of the health information. Confidentiality of adolescent individuals in the clinical context is approached differently in respective countries. In the US, abortion by teenagers without parents’ awareness stirred public debates since adolescents’ confidentiality was protected while the same adolescents could not give consent for other health care decisions. The famous argument in this matter was: “The school nurse cannot give your teenage daughter an aspirin for her headache without your permission, but that same daughter can get an abortion without even informing you” (Hill, 2012). Similarly in Australia, public debates took place when parents wanted to have access to their children’s health records who are 16 and under. Medical professionals opposed parental involvement in minors’ health with two arguments: there is no proven benefit of making parental involvement
obligatory, and concern over young people’s avoidance in seeking help for substance
abuse, sexual health and mental health issues (Sanci et al, 2005).

Those who suggest that parents should still be involved/informed in adolescents’
health care decisions argue that, in most cases, an adolescent’s medical and family
history can be provided only by parents. Moreover, parents could help adolescents to
understand all treatment alternatives and procedures and overcome unwanted results.
Anderson criticized the misquoting in research regarding this matter (2015):

There is no study that documents adverse outcomes due to parental
involvement laws prior to an adolescent’s abortion - there is no evidence of an
increase in child abuse, an increase in illegal or unsafe abortions, nor a significant
delay in obtaining abortions. The Henshaw and Kost study which is the most
cited and used by the American Academy of Pediatrics to support confidentiality
is misquoted and actually shows that only 2% of adolescent girls suffered
violence due to parental notification, rather than the 30% often cited (195).

Anderson mentioned the judicial bypass option when teens are afraid of
parents’ punishment. Some claim that the judicial bypass process causes delays in
abortion; however, some studies prove otherwise. Anderson claimed that overall the
benefit of parental involvement is more than the harm in adolescent health care:

... parental involvement laws have been shown in some studies to change
adolescent behavior, decreasing sexual activity and lowering the incidence of
STIs. In one study, abortion rates fell by 13.6% after enactment of a state
parental involvement law without an increase in birth rates, indicating
adolescent behavior was impacted (195).

Parker (2011) believed that adolescents’ confidentiality is needed for their
development by controlling their own information. However, he adds that health care
workers should encourage the adolescents to involve their parents unless there are valid
reasons to be concerned about parental involvement. Adolescent confidentiality can be
breached only when serious concern exists regarding their well-being, such as if the

13 A judicial bypass gives young people (who are under 18 and not emancipated) permission get an abortion without a parent’s
involvement in US. A young individual is supposed to apply to courthouse in person to apply for judicial bypass.
adolescent individual expresses their intention to commit suicide and shares their plan (18).

In Canada, two federal legislations regulate data collection and disclosure in health care: the Privacy Act and Personal Information Protection and Electronic Documents Act (PIPEDA). Patients’ privacy in the medical context is secured by these acts; however, there is no age specification regarding adolescents. In some cases, provincial regulations take precedence over PIPEDA. As stated earlier, HCP is in the position to judge the situation when an adolescent’s health care decision or confidentiality concern needs review. They decide if confidentiality should be prioritized based on the patient’s maturity level, attitude, familial factors and their psychosocial development. If the adolescent is a ‘mature minor’ with no other concerns, then they proceed with protecting the adolescent individual’s confidentiality. In Quebec, those 14 years old and above can control access to their health records according to the Act Respecting the Health Services and Social Services. Newfoundland and Labrador adolescents gain the same right at age 16 (Agostino and Toulany 2023).

Legal regulations regarding adolescents’ medical decision-making are mostly based on 1) their capability of understanding the content of the procedures and long-term consequences, and 2) their ability to control their emotions while making a decision. However, legislation regarding adolescents’ other rights and responsibilities differs depending on the context. Noroozi et al. (2018) criticized legislation in countries where minors can be charged as adults when they commit a crime, yet they have no right to consent on their own health care decisions. They think Canada is an example for other countries where minimum age for criminal responsibility (MACR) aligns with health legislation. According to Canadian law, a 12-year-old is mentally capable of committing a crime intentionally and can be convicted (85). However, according to Canada’s Youth Criminal Justice Act (YCJA), the consequences of the youth crimes would be different, focusing on ‘rehabilitation’ and ‘reintegration’ (Ricciardelli et a. 2018).

Reviewing the development of Canadian legislation throughout history shows the regulations evolving towards more rights and freedoms for adolescents where their
autonomy and privacy are respected while they are expected to take the responsibility of the consequences of their actions. However, more research is needed to contribute to improving the regulations to clarify its ambiguities regarding adolescent medical decision-making.
CHAPTER 5

Islamic Bioethics on Adolescence Decision-Making

In this chapter, Islamic bioethics perspectives on adolescence decision-making will be presented. To discuss the topic considering Islamic bioethics arguments, this new discipline will first be briefly introduced, and main approaches summarized. One reason for this is to present the limitations of this research and thus to indicate the need for frameworks in this discipline. Another reason is to show why this research suggests that Islamic bioethics as a growing field could answer our questions in clinical settings. After presenting the arguments in Islamic bioethics, our research question will be discussed through Islamic ethics (bioethics) principles and a conclusion will be drawn.

5.A. Islamic bioethics as a growing discipline

Islamic bioethics is a developing subfield of Islamic ethics, which deals with medical ethics and other bioethics issues. It can be described as a discipline that ‘uses Islamic tradition to address moral questions and ethical issues arising out of the biomedical sciences and allied health practice’ (Padela 2021, 4). In recent years, many articles have been written to discuss defining the discipline and exploring who will be the producers and consumers of this new developing field. It is a multidisciplinary area which requires combining medical science with Islamic sciences. Other disciplines, such as law and psychology, are included as informants as well depending on the issue.

Muslims trace the origins of Islamic bioethics to the Prophet Muhammad’s ﷺ time. Padela (2021) said that hadiths regarding permissibility of certain therapies and the teachings of the Prophet Muhammad ﷺ about healing could be the beginning of Islamic medical jurisprudence, hence Islamic bioethics. However, Padela thought that the literature regarding Islamic medical jurisprudence is not the only root of Islamic
bioethics. Moral formation, or in other words *adab*, provides many resources that serve as building blocks of Islamic bioethics. *Adab* translates into being a good practitioner and having the necessary qualifications in the medical context. Several books were written in early Islamic history regarding medical ethics. Ishaq ibn Ali al-Ruhawi (b. 931)’s book *Adab al-Tabib* (Practical Ethics of the Physician) is an example of this category. ‘Ali ibn al-‘Abbas al-Majusi (b. 982)’s and Abu Al Faraj ‘Ali ibn al-Husayn ibn Hindu (b. 1019)’s writings are still significant for contemporary Islamic bioethics today (6). Muhammad Zakariyya` Al Razi (b. 854 CE)’s book *Kitab al Hawi fi al-tibb* (The Comprehensive Book of Medicine) was considered one of the most valuable books of all time in which he explored medical ethics and other subjects (Amr and Tbakh, 2007 cited in Al Fattani and AlAlem 2020). Ibn Al Jazzar Al-Qayrawani (b. 898 CE)’s book on the principles in dealing with and management of children was monumental for guiding pediatricians for centuries (from Browne, 2001 cited in AlFattani and AlAlem; Dehghan & Farkhondehzadeh 2019).

Padela suggested that while approaching the history of Islamic bioethics, it could also be argued that Islamic bioethics is a recent development initiated out of the need to respond to the dominant secular bioethics discourse. According to this version of its history, Islamic bioethics is born from the need to answer questions arising from technological advancements. Muslim countries whose wealth was based on petrol founded *fiqh* councils, such as the Muslim World League and the Organization of Islamic Cooperation (previously named Organization of Islamic Conference) in the end of 1960s and beginning of 1970s. In the 1980s, Islamic jurists were facing biotechnical questions in these councils. Medical doctors with religious sensitivities and Western education were brought to these platforms to give their input in answering complex questions. This was the beginning of transnational (and *fiqh*-based) Islamic bioethics (Padela 2021, 7).

Padela (2021) listed Islamic bioethics “producers and consumers”. According to his categorization, Islamic bioethics consumers are Muslim patients and their surrogate decision makers, Muslim clinicians and their professional organizations, religious
leaders, *imams*, and Muslim chaplains, hospitals and healthcare systems, health policy lawmakers, academicians and researchers, and Islamic/Muslim bioethicists. The typology of Islamic bioethics producers includes Islamic jurists, Muslim clinicians, academic Islamic/religious studies experts, social scientists, Islamic/Muslim bioethicists, Muslim health professional organizations, juridical academies, and state authorities. Islamic jurists are authorized *muftis* or those who have the same credentials to issue fatawa. Muslim state authorities refer to ministries of health in Pakistan, Iran and Saudi Arabia who use Islam in their legislation (14-25).

According to Ghaly (2016)’s systematic Islamic bioethics literature review, published works in Islamic bioethics seem to fall into two main categories: attempts to present the compatibility of Western bioethics principles with Islamic tradition, and attempts to derive guiding principles from Islamic tradition. In the second category, researchers use the Qur’an and Sunnah as main sources; besides them, they resort to *maqasid al-Sharia* (higher objectives of Islamic law) and *qawā'id al fiqhiyya* (legal maxims) to derive ethical principles. Much research in Islamic bioethics follows a *principlist approach* today, either adapting Western bioethics principles as guidelines to a Muslim context or using Islamic ethics principles derived from Islamic sciences (3-6).

Today, Islamic bioethics remains under construction (Padela 2015). There is no systemic methodology to approach bioethical issues; however, most research in Islamic bioethics is highly legalistic, relying on fiqh. Thus, Islamic bioethics producers depend on fatawa and judicial opinions (*qararat*) in approaching issues (Padela 2021). For instance, Vardit Rispler-Chaim’s book *Islamic Medical Ethics in the Twentieth Century* is based on the fatawa that Egyptian scholars issued (Krawietz 1995; Padela 2021). Abul Fadl Mohsin Ebrahim investigated bioethics issues from legal perspectives (Ebrahim 1989; Ebrahim 1995). Mattson (2017) criticized the use of only fatawa while approaching complex issues since they only answer narrow questions rather than reflecting all concerns surrounding a specific issue. Moreover, she doubted that published fatawa present the most crucial concerns of lay people (59). Mattson’s ethical review of the ‘Sleeping Child Phenomenon’ is an example of how depending on fatawa in complex issues could lead
to more significant harm to individuals if the main principles of Islamic ethics are not considered (Mattson 2017, 66-72).

Ramadan (2018) also criticized the heavily legalistic approach in Islamic bioethics:

…it is clear that general ethical reflection, when it becomes a strictly legalistic examination whose only aim is to determine the licit (halal) and the illicit (haram), will be reduced to an exercise in jurisprudence that attends to novelty in detail but is unable to grasp the breadth and complexity of new situations created by scientific progress. A legalistic examination, therefore, neglects not only the paradigms that govern new ways of understanding, but also the theory of knowledge that generates meaning and the ethical questions generated by social, scientific, and intellectual development. Worse yet, these Islamic scholars more often lack a basic grasp and informed overview of the scientific elements and of the theoretical and practical information on the topics under discussion. Their overview (in both conceptual and temporal terms) of the subject is often deficient and uninformed by a holistic vision (15).

Regarding the involvement of medical experts and Islamic scholars in shaping Islamic bioethics, different views are presented in terms of their authoritative role. Stodolsky and Kholwadia used Shatibi’s ijtihad model to suggest that definitions should be made by Islamic scholars while medical professionals should examine the situation according to that information. For instance, regarding organ donation from a braindead person, Stodolsky and Kholwadia claimed that the concept of ‘death’ should be defined by Islamic scholars and the medical professional should examine if the person is dead according to Islamic criteria. (Stodolsky and Kholwadia 2021).

Ghaly (2015) stated that due to the unusual and complicated character of these issues, they require deliberate work; thus, Muslim scholars must conduct their ijtihad14 with deep investigation prior to issuing their ruling. Two components of ijtihad are vital for a sound decision in this regard: informative and normative components. The informative component facilitates obtaining the right information or accurate caption of the issue (tasawwur sahih), sometimes referred to as fahm al-waqi (understanding

14 This term will be explained in depth in next section. Ijtihad is a method used in Islamic law to approach issues that are arised after Prophet Muhammad’s time.
reality) or *taḥqīq al-manāt* (verifying underlying ground). Both pre-modern and modern Muslim scholars had consensus that professionals outside the religious sciences realm can be consulted during this process. Professionals that are consulted can be from different fields such as medicine, astronomy, architecture, economy and so on. The second component is called *taḏrīs al-hukm al-shārī* (forging the religious judgment), which refers to reviewing the question or issue from scriptural sources and interpreting through juristic procedure. At the end of this process, a conclusion is reached in most cases such as a religious ruling (*ḥukm shārī*). This role belongs to muftis to issue the ruling, whether or not experts are consulted. Ghaly stated that, in recent years, biomedical experts gradually evolved to act like co-muftis, meaning they did not only act as ‘informants’ but they offered their own perspectives on developing Islamic ethical methodologies to approach biomedical issues (286-288).

Hashmi (2021) suggested using Harvard’s *Principles of Religious Literacy* while developing a systematic approach in Islamic bioethics. According to this contributor, the first principle in doing Islamic bioethics should be *internal religious diversity*. From his perspective, most studies in Islamic bioethics ignore alternative religious views in contested issues and present only their own viewpoint. Hashmi proposes that Islamic bioethics should have internal diversity not only concerning the sects and schools of thought in Islam:

> Heterogeneity of Islamic thought cannot be reduced to sectarian affiliation or school of thought nor even to the traditionalist-modernist spectrum... At most what has been provided here is one additional lens through which the diversity of the Islamic landscape can be viewed. One does not necessarily need to embrace a post-modernist view of religion—in which *anything goes* and there can be no universal truths outside of historical, social, and cultural contexts—to appreciate the fact that there exist multiple and competing claims of truth sincerely held by various confessional actors and groups. This has long been appreciated by the Islamic tradition itself: Islamic scholars have simultaneously held their view to be the most correct even as they acknowledged the possibility of error and the validity (if not correctness) of other viewpoints (287).

Secondly, Hashmi suggested that Islamic bioethics should consider historical, social and cultural contexts while making interpretations. He thought that many scholars
fail to consider our time and needs in their analyses, such as with female circumcision rulings. He also criticized the overemphasis on law in the discipline for limiting internal diversity. According to Hashmi, restricting the whole discipline solely to ulamas’ (religious scholars’) legal rulings does not allow other voices to be heard and have the freedom to exercise different opinions (280-292). Mattson (2017) pointed out Bernard Weiss’s argument regarding the authority of jurists being only declarative, meaning, unless they are given a political or judicial appointment, the believers do not have to obey the ruling in theory. However, in practice, many Muslims strongly believe and try their best to obey judicial authorities due to loyalty, an inability to access alternative views or due to social pressure (59).

Our study focuses on Sunni sources in bioethics; however, one Shiite scholar Sachedina’s views are included since Sachedina stated that his work on ‘the principles of Islamic bioethics’ compiles all four Sunni schools’ and the Shiite perspective (Sachedina 2007, 275). In his foundational book called Islamic Biomedical Ethics, Sachedina suggested that Islamic ethical doctrines would allow engaging with secular bioethics. According to Sachedina, these doctrines have potential for an ‘inclusive universal language’ (Sachedina 2009, 8). Some Islamic ethics principles such as maslaha (public good) and la darar wa la dirar ‘no harm, no harassment’ are observed as compatible with Western bioethics’ main principles of beneficence and nonmaleficence. However, according to Sachedina, Western bioethics principles such as autonomy reflect liberal individualism, which differs from Islamic communitarian ethics (2007). Thus, in the case of medical decision-making, while patient autonomy is a high priority in the Western context, according to Sachedina the Islamic ethical approach would consider the individual in relation to religious and social ties. Some other Islamic bioethics experts shared this view as well, such as Al-Bar and Chamsi-Pasha (2015) and Rasool et al (2023).

Al-Bar and Chamsi-Pasha (2015) stated that ‘fully autonomous’ choice is not possible since family or other social ties as well as certain principles in Islam (e.g., ‘no killing’) should be considered (2015). However, it can be discussed here that according to al-Ghazali’s taklif perspective, a person cannot be forced to choose an action (Çetin
Even if there is a religious ruling to forbid an action, a person still can freely choose to do it and face the consequences. Thus, it could be said that people can autonomously decide by taking responsibility for results of their action in this world or the afterlife. Considering family or other people while deciding can be recommended; however, it cannot be mandated. This does not mean a person should not consider the possible harmful results of their action on other people; on the contrary, according to Islamic ethics, a person should consider the consequences of their actions on themselves and others, even on the environment. However, in the end, people have the autonomy to decide regardless and act on it.

Moreover, it can also be argued that the ‘autonomy’ concept was introduced to the Arabian Peninsula by Islam. The Quran talks to both women and men, and taklif is given to all people (who have the capacity and free will) without differentiation. For instance, Bay’ah al Aqabah (the Pledge of Allegiance in Aqabah) was one of the formative events of the Islamic society in Madinah where both women and men gave oaths to Prophet Muhammad ﷺ. They were informed what the oath meant and what actions and consequences could occur. Upon being informed, they made the oath with their free will without women being required to receive consent from their family members (Faruqi 2009).

Our research question regarding adolescent individuals’ medical decision-making from an Islamic ethical perspective is under the realm of Islamic bioethics. As explained earlier, there is no systematic approach nor manual for Islamic bioethics research, but rather the commonly practiced legalistic way of reviewing fatawa and making conclusions using Islamic jurisprudence as the main source. In this study, we aim to use a multidisciplinary approach by bringing the data from relevant disciplines such as developmental psychology, law, clinical ethics and Islamic theology, and review the issue under the light of Islamic ethics. Islamic legal sources will be included; however, instead of seeking fixed fatawa for our research matter, we will focus on ethical deliberations that guide rulings. In the next section, guiding principles of Islamic ethics will be reviewed in order to make ethical deliberations regarding our research topic.
5.B. Islamic Ethics Sources

Islamic ethics is derived from many sources, as mentioned in the previous section. The primary sources of Islamic ethics are the Quran and Sunnah. Sunnah includes all the authentic sayings of Prophet Muhammad ﷺ as well as his actions, habits and his tacit approval or disapproval, and can offer an explanation and interpretation of the divine law; but it also needs contextualization and interpretation. In Islamic law, a methodology was developed to approach issues arising after Prophet Muhammad ﷺ’s time. Among the methods presented in different schools of thought in Sunni Islam, Ebrahim (2012) emphasized the significance of ijtihad in medical jurisprudence. The word *ijtihad* is rooted in the verb *jahada* and means “to strive, to exert oneself, to struggle.” Legally, it refers to the jurist’s endeavour to apply the teachings of the Quran and Sunnah to a particular case with the intention of finding a solution (40).

Hallaq (1984) defined ijtihad as “the maximum effort expended by the jurist to master and apply the principles and rules of *usul al-fiqh* (legal theory) for the purpose of discovering God’s law” (3). Ijtihad has two branches: *‘ijma*‘ and *qiyas*. *‘ijma*‘ refers to Muslim jurists’ coming together to agreeably answer a question of law. Once they reach consensus, this is used as basis for future ijtihad. Qiyas is a “process of deduction by which the law of a text is applied to such cases which, though not covered by the language of the text, are covered by the reason of the text on the basis of the ’illah (effective cause)” (Ebrahim 2012, 40-41). In short, qiyas can be understood as using comparison and analogy in law-making. It was used to compare “two similar cases and meeting a new situation by the rule of law applied to its precedent” (Hasan 1980, 2).

It must be noted here that ijtihad had been one of the most discussed topics of usul al fiqh. Some scholars claimed that the ijtihad gate was closed around the end of the 3rd century AH (around 900 CE). According to that view, Muslim jurists from all schools of fiqh concluded that all essential questions had been discussed in depth and
finalized. That led to the birth of a new method called *taklīd*, meaning ‘unquestioning acceptance of the doctrines of established schools and authorities’. Hallaq (1984) gave examples from Islamic history to show how that was not the case, that the ijtihad door was never closed. He stated that the principle of *qiyaṣ* was condemned by anti-ijtihad trends and gave the Zahirī school as an example of this movement (8). Schools of thought also had different positions regarding the existence of mujtahids. While the Hanbali and Shafi’i schools claimed that mujtahids existed at all times, the Hanafi and Maliki schools opposed that view (33).

Besides the methods of deriving principles from the Quran and Sunnah, and ijtihad, *Maqaṣid al-Sharia* serves as one of the main guidelines in Islamic law and Islamic ethics. The word *maqaṣid* means ‘purposes’ in Arabic; however, it is referred to as “intentions, as well as objectives and goals such as pertinent to general activities, institutions and policies” (Abd-Allah 2012, 39). *Maqaṣid al-Sharia* is translated as ‘higher objectives of divine law’, and is a theory which was elaborated in detail by Abu Ishaq al-Shaṭibi (d. 790 AH/1388 CE), a 14th-century Sunni legal theorist and Maliki jurist, although other scholars before him discussed this framework for legal and ethical reasoning. Padela said: “Maqaṣid al-Sharia ...refers to the purposes and intents of the Lawgiver in legislating”. According to this theory, every ruling has an aspect of human interest and God, as divine Lawgiver, intends to protect those interests. Al-Shaṭibi identified five essential (*daruri*) higher objectives: the preservation of religion (*din*), human life (*nasf*), progeny (*nasl*), material wealth (*mal*), and intellect (*‘aql*) (76). The meanings of these terms are understood differently by various scholars. For instance, *nasl* is translated as “children” instead of progeny, and *aql* is translated as “reason” (Abd-Allah 2012) or “mind” (Al-Bar and Chamsi-Pasha 2015) instead of intellect. Honour (*al-‘irdh*) is included among higher objectives in some sources as well. Al-Bar and Chamsi-Pasha cited the explanation given by the 14th century jurist Ibn Qayyim:

> Al-Shari‘ah fundamentals are built on keeping the interests (*masalih*) of the people during this life and hereafter. These objectives are built on justice, mercy, wisdom and interest of the creatures. Therefore, any situation which perverts
from justice to injustice, from mercy to cruelty, from wisdom and utility to chaos and futility is outside the scope of Shari’ah. (Al-Bar and Chamsi-Pasha 2015, 50).

Al-Shaṭibi applied a different type of categorization within the maqasid (objectives) according to their significance as daruri (essential), ha haji (needed), and tahsini (recommended/enhancing). Daruri is used for essential maqasid whose absence causes death, corruption in this world and losing blessings of the afterlife. Haji are the maqāṣid that remove difficulties and bring certain accommodations to life. Tahsini refers to obtaining ‘good manners’ and avoiding harmful ones for perfection in behaviours (Padela 2022; Hallaq 2009, 104-105; Al-Bar and Chamsi-Pasha 2015).

Padela (2022) demonstrated this hierarchical order in the example of food delivery. Daruri can be considered as moral obligation to ensure food is available since it is essential for preserving life. Haji would be making sure the food is nutritious and tahsini would be ensuring the food is delivered and consumed with good etiquette. When food is scarce, concerns about the nutritional value of food items and table etiquette do not replace the moral obligation to alleviate hunger through eating (27).

Ibrahim et al. (2019) summarized the process of using maqāṣid al-Sharia in bioethics issues in the Figure 4. According to them, maqāṣid al-Sharia allows researchers to consider a bioethical issue in a ‘contextual and comprehensive’ manner. They thought that analyzing the context background of, say, a certain proposed technology, related parties and purpose of the invention would allow evaluating the intention of developing this technology. While some new technologies are developed to serve essential needs of humanity (daruri), others are developed to fulfill more discretionary interests (tahsini). In this process, technology itself is also assessed to scrutinize if it is compatible with Islamic teachings (342). Raquib (2015, cited in Ibrahim et al. 2019) stated:

The analysis of the purpose of a technology seeks to examine whether the technology serves to fulfil the needs of humankind or otherwise. Any technology that is based on the idea of “whatever can be done should be done” is against Quranic teachings, which urge people to live with purpose. A technology without a purpose and not based on human needs leads to endless development (342).
Raquib’s simplified assessment begs two qualifying questions: ‘Is the purpose sound and acceptable?’, and ‘Who is qualified to judge the purpose?’.

**Figure 4**: Identification flow of technological implications according to maqasid al-Sharia-based Islamic bioethics (Ibrahim et al. 2019, 342)

*Istihsan* is a significant term in Islamic jurisprudence when facing new situations; thus, it is used widely when approaching bioethical issues. The word itself literally means ‘something good, beautiful and preferable’. Istihsan in a legal context refers to the process of prioritization of two or more legitimate judgments by using the juristic methodology. (Kamali 2004; Sachedina 2007, 121). Islamic schools of law vary in how they approach this concept. Some Hanafi scholars defined istihsan as ‘evidence (*dalīl*) which occurs to the mind of the mujtahid but he hesitates to articulate it in words’ (Hasan 1992, cited in Kamali 2004, 563). According to this definition, istihsan is subjective and relies on the jurist’s understanding. While the Hanafi school prioritized ‘*darūra*’ in applying istihsan, the Maliki school based istihsan on ‘*maslaha*’. Different reports are stated regarding Imām Ahmad bin Hanbal’s view; however, a prominent Hanbali scholar Abd Allah bin Muhammad Ibn Qudamah (d. 620 AH/1223 CE) was against istihsan. While the concept remained relevant in the Hanbali school, Imam Shafi’i rejected it outright. He warned that if a mujtahid does not give their fatwa based
on revelation (or does not apply ijtihad based on a revelation), it would not be valid
since it represents ‘indulging in personal preference’ (Kamali 2004, 571).

In the history of Islamic law, when new conditions occurred and it was
impossible to apply established law in new situations, istihsan was used in favour of
justice (Yusuf 1992, 2; Hasan 1977, 347). Hasan (1977) stated that “it is designed to make
up the defect in law owing to its generality or to remove its rigidity...Istihsan is
preferential reasoning”. It was used to remove unfair judgments arising from qiyas
(347).

Another significant feature of Islamic law used by Islamic ethicists is al-qawa’id
al-fiqhiyyah (legal maxims), as follows:

1. Matters/acts will be judged by their intentions/purposes;
2. Certainty will not be overturned/removed by doubt;
3. Harm must be removed;
4. Hardship must be alleviated;
5. Custom has the weight of law/custom is determinative (Abd-Allah 2012, 5;
Musa 2014, 331).

These maxims are at the center of all other Islamic legal maxims and are closely
related to maqasid al Sharia. The maxim of ‘acts will be judged by their intentions’ is a
general rule based on a hadith (‘acts are valued in accordance with their underlying
intentions’). The significance of ‘intent’ can differentiate a murder from an accidental
killing (Kamali 2006, 88). The ‘certainty will not be removed by doubt’ maxim means
‘knowledge based on valid experience and strong evidence must not be overturned by
weaker considerations’. It is based on the verse, “And do not follow that of which you
have no true knowledge’ (Quran 17:36). One of the common applications of this maxim
is ‘presumption of permissibility’, meaning to assume things are permissible unless it is
proven to be otherwise (Abd-Allah 2012, 44). The third maxim - ‘harm must be
eliminated’ - is based on a hadith ‘la darara wa la dirar’ meaning ‘let there be no
infliction of harm nor reciprocation’. Harm here can be understood as overall detriment
of one’s condition, considering all overt and assumed effects. For example, fasting can
lead to hunger, exhaustion and irritability, but the benefit from God’s pleasure, eventual humility, social consciousness, better health, and so forth is taken as greater. With that said, the rule in Islamic law called ‘khiyar al-‘ayb’ protects the buyer from harm. According to this regulation, if a person buys an item and realizes it had a substantial defect, the buyer can revoke the contract (Kamali 2006, 87).

Al-Bar and Chamsi-Pasha listed how the ‘harm must be eliminated’ maxim is practiced in Islamic ethics:

1. Doing harm and reciprocating harm is not allowed.
2. Harm should be warded off and avoided as much as possible.
3. All that is harmful is prohibited in shariah.
4. If there is certain harm, then it should be removed.
5. Harm should not be removed by another harm, which is equivalent to or worse than the previous harm.
6. Greater harm could be replaced by lesser harm. Examples of this in medicine are limb amputations if gangrene is spreading or using narcotics to lessen pain.
7. Prohibited things would be allowed if necessary. If a person is lost in the desert and thirsty with only alcoholic drinks around, then he is allowed to drink it to quench his thirst.
8. As long as harm continues, it cannot be ignored. So long as the harmful effect is there, then it should be removed.
9. The harm befalling a whole community is worse than the harm falling on an individual. The general harm should be warded off first. If the general harm cannot be prevented unless it affects a few, then the general harm should be prevented, even if it involves one or few individuals.
10. If two harms exist, then the lesser harm could be done if it is impossible to ward off both harms.
11. If two benefits exist, then the higher benefit should be obtained, even if it involves losing the lesser one.
12. If both harm and benefit are involved, then try to get the benefit and refuse the harm. If that is not possible and the benefit is much greater than the harm, then accept the harm. However, if the harm is equal or even more than the benefit, then refuse the harm even if it means loss of the benefit.
13. “Legal permission negates tortious liability,” except in cases of flagrant negligence. These rules have great bearing in medical practice from both the ethical and legal points of view. The law differentiates between crime and tort (119-121).
The fourth maxim ‘hardship must be alleviated’ is based on many Quranic verses and hadiths. The Quran says: ‘God intends for you ease and He does not intend to put you in hardship’ (2:185). The jurists use this maxim to make exceptions for sick and disabled people in religious responsibilities and civil transactions (Kamali 2006, 87).

‘Custom has the weight of the law/custom is determinative’ is a maxim that acknowledges the role of custom in people’s lives. The Quran says: “Accept from people what comes naturally for them; command what is good by custom; and turn away from the ignorant without responding in kind” (Surat al-A’raf:199). Prophet Muhammad ﷺ respected cultural differences and lived with various ethnicities peacefully. As a prophet, he only corrected as necessary (Abd-Allah 2012). It was reported that when Hind the daughter of Utbah complained about her husband not sharing the wealth with his family, Prophet Muhammad ﷺ advised her to take what she and her son needed according to their custom (urf) (Zakariyah 2009, 193; Zakariyah 2012, 81).

Abd-Allah (2012) stated that these maxims present the essence of the ‘operative wisdom of Islam’. He also suggested “five operational principles” as a framework for American Muslims, while adding that they could also apply to Muslims in Canada, Britain and Western Europe. These principles are:

- Trusting reason;
- Respecting dissent;
- Stressing societal obligations;
- Setting priorities;
- Embracing maxims.

According to Abd-Allah (2012), these principles function as a bridge between Islam and other cultures and religions due to the core values and universal principles. ‘Trusting reason’ is a significant feature in this framework due to the centrality of ‘reason’ in the Islamic worldview. Human beings are created with reason and gifted with dignity. Abd-Allah stated: ‘The protection, preservation, and cultivation of the power to reason count among the major objectives and greatest societal obligations of Islamic law’ (6). Sheikh Muhammad Draz (2008) also argued in *The Moral World of the Qur’an* that there would not be ethics without the faculty of reason since it is essential to
comprehend obligation (*faridah*) and responsibility (*mas’uliyyah*) (4-16 as cited in Ramadan 2018).

Abd-Allah (2012) pointed out that “Islam only speaks with a monolithic voice on foundational beliefs and practices”; thus, Islam allows different opinions in all other matters. ‘Respecting dissent’ is a principle to protect that diversity for intellectual development as well as for a society that functions harmoniously. Although ‘societal obligations’ are normally legal matters, Abd-Allah emphasized their significance in Islamic ethics due to their ethical origin by being respectful of others’ dignity. The Quran makes the connection between good character and moral obligations towards others. The ‘setting priorities’ principle refers to accounting for and prioritizing relevant benefits and harms. Abd-Allah mentioned that Islamic law provides the criteria on how to do that prioritization through ‘daruri, haji, and tahsini’ concepts and providing the list of most essential purposes to protect in life as the maqasid al-Sharia. ‘Embracing maxims’ refers to knowing core maxims and applying them in daily lives (6-38).

According to al-Ghazali, when facing an ethical conflict, the situation must first be reviewed through the lenses of the Quran, Sunnah and ‘ijma’ to see if established guidance exists. If not, then an analogy-based procedure is followed. If a conclusion cannot be reached, then an ijtihad process starts. Avci (2023) summarized al-Ghazali’s directions in applying ijtihad:

Firstly, exercising *ijtihad* must result from an obligation. Secondly, forging a new decree stipulates the protection of the five leading values: religion, life, reason, lineage, and property. Thirdly, the ruling must be established on the certainty or near certainty of the benefits and risks. Fourthly, the protection of the five values must be actualized according to what creates the greatest good for the community. By this point, the deontological stance of al-Ghazālī’s view turns into a utilitarian position. Fifthly, in the event of a conflict between public and individual interests, *maslahat* prioritizes public interests over individual interests. Sixthly, harm to one value may be justifiable by producing a greater benefit to another value. Seventhly, while more than one harmful situation exists, the less harmful one must be chosen. Finally, when any conflict appears between life and property, the protection of life is prioritized over the protection of property (Al-Ghazālī, 1994). In this sense, even though the protection of the five values is crucial, they should not be deemed absolute values, but *prima facie* (fig 6)(9).
The *maslaha* concept is central in handling Islamic legal issues. According to Sachedina (2009), maslaha (public good) is a general principle that provides solutions to most issues. Maslaha as a term refers to promoting benefit and preventing and removing harm even though different approaches to the term exist (47-48). Al-Ghazali categorized maslaha into three types according to how they are approached by Sharia. The first category refers to circumstances that the Sharia explicitly confirms. These situations resemble analogical reasoning (qiyas), like when certain substances that reduce human consciousness are forbidden by drawing an analogy with the prohibition of alcohol and other intoxicants.

The second kind of maslaha pertains to matters that the Sharia clearly deems invalid. For example, in the Sunni tradition, breaking the fast during Ramadan by engaging in sexual activity requires the emancipation of a slave; if the offender cannot afford this, they must fast for two uninterrupted months or feed 60 poor people. Al-Ghazali (1994) then provides an example of a monarch who invalidates his fast during Ramadan by having sex. Despite some jurists suggesting that it might be unfairly easier for the monarch to free a slave, and this might lead to repeated sinning, it is not permissible to insist on the two months of fasting, as the initial requirement of the law is to free a slave and one should not question the logic behind it. The third category of maslaha, also known as *maslaha-i mursala*, deals with issues that religious sources neither explicitly approve nor deny (Avci 2023).

In the history of Islamic law, this term was found in legal writings around the 2nd-3rd AH/8th-9th CE centuries. It was a jurist’s role to decide what was good for the Muslim community. Till the 5th AH/11th CE century, Muslim jurists treated maslaha as ‘the embodiment of the purpose of the law’ (Opwis 2005, 183, 187). However, in secular societies today, where Islamic law is not the main legal system, the questions of who will decide on ‘harms’ and ‘benefits’ of an action and how to apply maslaha principles are not clear. Some scholars such as Taha Jabir Al-Alwani and Yusuf Al-Qaradawi introduced *fiqh al-aqalliyyat* (the jurisprudence of Muslim minorities) in the 1990s to
help Muslim minorities in their unique circumstances and questions. According to them, Muslim minorities should be accommodated according to their needs. Al-Alwani said:

We cannot include Fiqh al-Aqaliyyat in the meaning of Fiqh as it is now commonly understood: namely, applied branches of Fiqh (Fiqh al-Furu’). It is more appropriate to include it under Fiqh in the general sense, which includes all aspects of law in thought and practice.... This means [in this sense] that Fiqh al-Aqaliyyat is a Fiqh of quality, which facilitates the link between Sharia law and the conditions of the group and the place where it lives. Therefore, this is the Fiqh of a group confined to special conditions that is permitted to do what others are not permitted. Its discourse requires mastering some disciplines of social studies, especially sociology, economics, political science and inter- national relations (Parray 2012, 103-104).

Sartell and Padela (2015) recognized the significance of Islamic law in Islamic medical ethics and pointed out that adab as the virtue-based perspective also needs to be considered in evaluating the issues. In Islamic law, actions are sorted into five ethico-legal categories based on their perceived ramifications in the afterlife. Obligatory actions (waajib or farḍ) are rewarded if fulfilled, while failing to do them results in punishment. Recommended actions (mandub or mustahabb) are rewarded but not punishable if not performed. Indifferent actions (mubah) have no rewards nor punishments associated with them. Reprehensible actions (makruh) are discouraged, and abstaining from them is rewarded, but performing them is not punished. Prohibited actions (haram) are not allowed and abstaining from them is rewarded while committing them is punished (757).
Current Islamic medical ethics practice relies heavily on Sharia-based discourse, meaning it approaches ethical issues in a medical context by seeking to answer if certain applications are haram, makruh, mandub, mustahab and so on. However, ethics is more than just a theoretical exercise in determining religious obligations. According to Sartell and Padela (2015), *adabi* discourse, which enriches fiqhi assessments using virtues, offers a complementary approach to Islamic medical ethics. It recognizes the reciprocal

**Figure 5**: Application of maslaha in bioethical issues (Avci 2023, 10).
relationship between obligation-based ethical theory and virtue-based ethical theory, thereby enriching the broader implications of Islamic medical ethics.

The term "adab" in Arabic encompasses different meanings, including virtue, moral conduct, ethics, manners, etiquette, and praiseworthy qualities. It is seen as a way to invite people to something good and is conceptualized as virtues and the process of inculcating them. Adab represents both the end goal and the means of achieving it. It has a wide range of literature genres, including belles-lettres, Sunnah, and Aristotelian virtue. Sartell and Padela (2015) reviewed the adab concept presented by Al-Ghazali. Al-Ghazali’s understanding of adab is framed as ‘disciplining the soul’. While Sharia focuses on external actions, adab deals with both internal and external actions and how one affects the other. In a medical context, adab enables physicians to perform good deeds and provides guidance on virtuous behaviour. It bridges the gap between obligation-based ethics and virtue-based ethics, recognizing the importance of both aspects. Adab addresses religious responsibilities and virtues beyond obligations, such as compassion in the physician-patient relationship. Integrating Sharia and adab is crucial for a comprehensive understanding of Islamic medical ethics (759-760).

We summarized the most common sources used in Islamic ethics. In the next section, medical decision-making concerning adolescents from an Islamic perspective will be discussed through these tools and in the axis of the taklif concept. Then, finally, a conclusion/framework will be drawn upon the assessment of this matter.

5.C. Adolescence Medical Decision-Making from an Islamic Ethics Perspective in the Canadian Context

Adolescence medical decision-making can be reviewed in many aspects in Islamic ethics. Who do we mean in Islamic terms by saying ‘adolescent’? Can adolescents make autonomous decisions? In which medical issues can they give consent? Can parents be involved in the decision mechanism? What should be done if conflicts of opinion arise among the parties (adolescents/parents or guardians/health care workers)? How can
physicians benefit from Islamic ethics frameworks while helping Muslim adolescents in the Canadian context?

This research attempts to tackle these questions by using the principlist approach. Objectives of Sharia, legal maxims, and other Islamic ethical principles or sources will be referred to when relevant.

Guiding principles do not have to be limited to the ones listed here. As long as ethical principles are derived from the sources of Islamic ethics, they can be used to review the matter. The principles listed here are the most common ones, particularly in Islamic jurisprudence.

5.C. 1. Taklif / Trusting reason / Certainty Cannot be Overturned by Doubt

When the term ‘adolescence’ is used in modern psychology, it refers to the age group between 10 and 19 years based on the World Health Organization (WHO)’s age criterion (Choudhury et al. 2006). It is difficult to assume that the term ‘adolescent’ in modern psychology fully matches the term baligh (one with bulugh) in Islamic terminology in the developmental sense. Baligh is translated as adolescent in English; however, there is no fixed age in Islamic law for adolescence unless it is delayed, in which case 15 years is the accepted deadline (Mohd et al. 2018). In our research, WHO’s criterion is used for adolescence (10–19-year-old individuals). In summary, according to Islamic law, that 10-19 age group includes children from 10 years old till they reach bulugh, baligh individuals (who are in bulugh) and rashid individuals (who have rushd). It is difficult to generalize in that group regarding their decision capacity since it is a large group covering different developmental stages. In Canadian law as well, adolescents are not regarded as one group, as the legislation is either age-based (14 years and older, etc.) or competence judgment is left to health care workers.

In Islamic theology, taklif is central to explaining a human’s actions in this world. According to Sachedina (2007):
...authoritative decisions in matters of social ethics could not be derived without first determining the nature of human acts under obligation (taklif). The divine command, understood in terms of religious-moral obligation (taklif), provided the entire ethical code of conduct and a teleological view of humans and the world. More pertinently, violation of divine command, as Muslim jurists taught, is immoral on the grounds that it interferes with the pursuit of human goal of achieving perfection that would guarantee salvation in the Hereafter. Ultimately, human salvation is directly connected with human conduct the subject matter of legal-theological ethics (121).

As explained in the first chapter, taklif refers to the capacity for morality in human beings and a necessary condition for them to be charged with rights, responsibilities and duties, with the person having taklif being called mukallaf. Among the conditions of being ‘mukallaf’, a few deemed significant to our research are aql (intellect), bulugh (adolescence) and fahm (comprehension). To have certain rights and responsibilities in Islam, an individual has to reach adolescence, has to have the intellect to grasp the concepts that are in taklif content, and be able to differentiate good from evil. Adolescents (baligh) in Islamic terminology acquire the rights and responsibilities of a mukallaf. However, in order to earn all rights and have the full capacity to make decisions, the ahliyya (capacity or competence) term has to be considered. In Islamic law, full competence/capacity means an individual using their rights and legal actions. Full competence is not earned in bulugh solely by reaching sexual maturity; it (ahliyyat al ada al kamila) is earned with reaching rushd. That is why rushd is also used as ‘age of majority’ in Islamic law.

Taklif is only given to those who reach sexual maturity. Those who have not reached it are not mukallaf. Although it is not our topic to discuss adolescence in depth here, sexual maturity being accepted as a milestone in Islamic law seems to make sense when multiple transformations in the brain and hormonal changes in the body during this stage are considered. The body’s awakening as a clock (Susman and Rogol 2004, 22-23) to develop the reproductive system and the leap in cognitive development (Steinberg 2017) in this period are indicators of sexual maturity’s relation in being the sign of a significant developmental period. However, as al-Ghazali said: ‘starting to produce seminal fluid does not increase one’s intelligence’. The cognitive capacity of a
human being varies, and some adolescents can have more capacity than others. That is why rushd was required for taklif according to some scholars to make sure they are fully capable of understanding the taklif content (Çalış 2004, 110).

According to our literature review, rushd seems to be another key concept in adolescence decision-making in Islam. Although bulugh is a remarkable milestone in evolving to adulthood, for certain decisions such as financial contracts, Islamic law requires individuals to reach rushd. It signifies ‘competence’, and Hanafi scholar al-Zarqa defined it as "the ability to see and foresee risks and accordingly make reasonably good decisions regarding one's own actions and transactions’ (Zahraa 1996, 250). Medical decisions include serious situations such as lifesaving or sustaining interventions or end-of-life decisions. Thus, they also require the ability to see the risks and have the capacity to make a ‘reasonably good decision’. A literature review shows that two major systems play a crucial role in decision-making: cognitive-control and socioemotional systems. The cognitive-control system encompasses deliberate, intentional, and rational responses that require time and effort, while the socioemotional system, which includes the limbic and paralimbic systems, involves rapid and unconscious automatic responses that influence behaviour through emotions. Both systems play a crucial role in the process of making a sound decision (Diekema 2020). Adolescents can reason and foresee potential risks; however, in situations involving emotions, their limbic system can override their prefrontal cortex (Casey at al. 2008). Adolescents’ tendencies in risk-taking or reward-seeking behaviours and their disadvantageous situation in emotional regulation might prevent them from making a good decision.

The maxim of ‘certainty cannot be overturned by doubt’ in the Islamic ethico-legal tradition prioritizes facts over doubtful situations. In a medical decision-making context, no certainty exists regarding all adolescents being capable of making good medical decisions. However, it does not mean adolescents cannot make any medical decisions either. It does show that adolescents cannot be referred to as one undifferentiated group since the age window is wide and their competencies differ. Furthermore, in serious health care matters, even older adolescents should not decide
alone since they have more potential to focus on reward and miss the risks while under the effect of emotions. For instance, bariatric surgeries are common with overweight adolescents. These surgeries have high risks; however, for a young person, their ‘body image’ can make them anxious about being accepted in their peer group and can override the significance of health concerns (Martinelli et al. 2023). Similarly, in cosmetic surgeries, ‘conforming to their peer group’ is a major concern for adolescents beside the actual cosmetic issue (Singh 2015). Older adolescents who have rushd would be able to judge the situation more clearly according to parameters set by Islamic law. It should be underlined here, one common factor with rushd in Islamic law and the ‘emancipated minor’ term in Canadian law is that both emphasize the capacity to handle financial matters as a sign of competence. When adolescents’ capacity is judged by health care workers, their financial capabilities could act as a competence-judging criterion.

Although these generalizations are made here for adolescents, they are not a homogenous group as mentioned earlier; thus, their ability to make autonomous decisions depends on the individual as well (Flyn et al. 2014). Some adolescents show adult-like intellectual and emotional maturity (Piker 2011, 204). Based on the available scientific data, it is possible to assume that some adolescents have the necessary competence and can give consent for medical treatments or other interventions since the criterion here is to make sure the adolescent individual is able to make sound decisions according to the ‘certainty cannot be overturned by doubt’ principle. If certainty is present regarding the adolescent’s competence, then they can proceed with making the decision; however, if concerns appear regarding the decision capacity of the adolescent, then another mechanism should be applied.

As the literature review indicated, regulations regarding adolescent medical decision-making in Canada vary across provinces. Clinical workers who deal with Muslim adolescents can: 1) ask the family’s opinion regarding the adolescent’s maturity; 2) review the adolescent’s autonomy based on observations such as their financial awareness; 3) review the adolescent’s medical history for experience in medical decision-making and any familiarity with the considered intervention; 4) use any
available relevant tools and their discretion to assess the capacity of the adolescent in autonomous decision-making, if no fixed age regulation exists in the province and the adolescent would like to consent or dissent for a medical intervention; 5) ensure the adolescent is able to comprehend the process and consequences of the intervention.

We emphasized the critical role of the ‘certainty’ factor in the matter of determining adolescents’ competence in medical decision-making as one of the principles in Islamic ethics. Another related principle here is trusting reason. Suggested as one the operational principles by Abd-Allah (2012), it focuses on the importance of tapping into one’s ‘reason’. That principle centralizes the moral responsibility (taklif) in Islamic ethics since if there is no capacity to reason, there would not be any responsibility either (5-6). If an adolescent shows signs of cognitive development and competence, this proposition respects their autonomous reasoning. For instance, if an adolescent would like to try a new medical intervention or get involved in medical research, and indications show they have competence and are able to reason why they would like to proceed with this procedure and are aware of its details and possible consequences, then their reasoning should be respected.

5.C.2. Matters will be Judged by their Intentions

Medical interventions and adolescent individuals’ reasons to consider or reject them vary. In Islamic ethics, intention is prime. When adolescents are positioned to decide on their health, it is vital to carefully determine their intention. As summarized in Ibrahim et al. (2019)’s work, analyzing the background of the technology, related parties, and purpose of the invention can be applied here. In our context: 1) a medical intervention, 2) its participants in decision-making (doctor, dentist, surgeon, parent, guardian etc.), and 3) its aims should be analyzed. Moreover, risks and possible consequences of the intervention should be put at the table as well for a comprehensive evaluation. Intention is noteworthy to decide if this intervention is daruri, haji or tahsini. We can assume two different scenarios here to demonstrate the process.
1. An adolescent is offered a therapy method that seems to be the only treatment against a deadly disease. However, this person considers rejecting the therapy due to the risk of losing their hair and other cosmetic deformities. The doctor’s opinion regarding the necessity of this treatment is essential to judge wisely.

2. An adolescent would like to go through a rhinoplasty surgery. Although they do not have an abnormal look, many people in their social environment praise facial perfection and thus the self-confidence of the individual is affected from this situation.

In the first scenario, the adolescent considers rejecting a life-saving intervention. The purpose of the therapy is curing a deadly disease. According to maqasid al-Sharia, protection of life is the primary objective since one can only fulfill their responsibilities to God while alive. While the therapy here seems to be ‘daruri’, the intention of the adolescent to reject the therapy can be discussed if it is either haji or tahsini; however, it is not daruri. Thus, in that situation, the intention of rejecting treatment seems illegitimate from an Islamic ethics perspective.

In the second scenario, the adolescent considers consenting for an intervention which does not improve overall physical health. Its purpose seems to be purely aesthetical; thus, the intention of going through this procedure could be categorized as tahsini. However, the psychological health of the adolescent should be consulted with an expert since it is not possible to know how much that individual suffers from this issue. In Islamic law, altering one’s physical appearance is not allowed unless to correct a defect (whether from birth or later). Moreover, if an ugly appearance in certain body parts (not a defect) causes serious psychological harm, its correction might be allowed as well (Atiyeh et al. 2007). According to Islamic law, a psychologist or psychiatrist could make an assessment of necessity in these cases. If the intensity of the psychological harm is severe, the procedure could be haji, depending on the situation. These scenarios have many tangible variables that could change the course of the situation; however,
the purpose of using these scenarios is to show the ethical concerns that an Islamic perspective could help define and resolve in such conflicting cases.

5.B. 3. Harm Must be Eliminated

When adolescents are in medically harmful situations, the decision should be towards removing harm for the adolescents’ well-being. As demonstrated under the previous principle of ‘matters will be judged by their intentions’, if an adolescent wants to dissent to a therapy that their doctor proposes as a life-saving treatment, the doctor’s advice should be favoured since it serves the adolescent’s well-being by ‘removing the harm’. In the Canadian context (unless the provincial regulation differs), the aim to protect children and adolescents from harm leads to asymmetry between assent (accepting a procedure/action) and dissent (refusing a procedure/action) as explained in the previous chapter. According to that asymmetry, the adolescent (specifically one under the age of consent) can assent to a medical intervention; however, they cannot dissent if risk of harm exists (Montreuil et al. 2020). In Islamic ethics, based on the hadith ‘la darara wa la dira’ meaning ‘let there be no infliction of harm nor reciprocation’, eliminating the harm bears high priority, sidelining concerns such as patient preferences.

Related to this maxim, actions that alleviate harm should also be prioritized according to the harm should be alleviated principle. Sometimes, lesser harm is allowed to prevent the greater harm. Izz al-Din ibn Abdul Salam (d 660H/1262 CE) said:

The aim of medicine is to preserve health, restore it when it is lost; remove ailment or reduce its effect. To reach that goal it may be essential to accept the lesser harm, in order to ward off a greater harm, or lose a certain benefit to procure a greater one. (as cited in Al-Bar and Chamsi-Pasha 2015, 119).

In the adolescence medical decision-making process, harm could be caused by a medical condition such as disease or other factors. Conflicting opinions with parents regarding certain treatments can harm adolescent patients if the process is mismanaged. For instance, if an adolescent is advised to take antidepressants for
depression while their parents disallow, the adolescent can suffer. In such a scenario, the adolescent’s well-being can be at risk. Although such a scenario might be unlikely, the stigma towards mental health issues or alternative treatments can lead parents to take certain risks. In Islamic ethics, if prioritization is necessary between eliminating harm and promoting benefit, eliminating the harm would be the higher priority unless the benefit is so great that harm becomes acceptable to gain that benefit (Al-Bar & Chamsi-Pasha 2015; Sachedina 2009, 75). In this example, in order to remove the harm, the adolescent should be able to consent to take the medicine.

**5.C. 4. Maqasid al-Sharia**

Five objectives of the Sharia can be applied to all aspects of life since they aim to protect people’s most significant priorities. Adolescents who reach bulugh are considered as mukallaf with religious obligations and legal bindings in Islamic law barring financial rights and responsibilities. According to Islamic law, they have certain rights and responsibilities and are exempt from some, as earlier covered. Their vulnerability puts them in the position to be protected by their guardians when unable to protect themselves from harm.

In the medical context in Canada, the majority of provinces empower adolescents to consent to medical decision-making with certain exceptions. When a fixed age is not stipulated, the decision-making is shared by the adolescent, parent or guardian and the health professional. According to maqasid al-Sharia, **preservation of life** is the most significant objective and cannot be risked under any circumstances. Thus, when adolescents demand certain interventions that risk their life directly or indirectly, their guardians are in the position to protect their life by overruling. Medical assistance in dying (MAID) is the procedure whereby a person intends to terminate their life through the assistance of a physician due to severe pain or difficulty caused by an illness. In Canadian law, when an adolescent turns 18, they are able to ask for MAID when under intense illness-induced suffering (Health Canada 2015). The trial judge’s
finding in *Carter v. Canada* was acknowledged by the Supreme Court (in para. 24, as cited in Davies 2018):

... while there is no clear societal consensus on physician-assisted dying, there is a strong consensus that it would only be ethical with respect to voluntary adults who are competent, informed, grievously and irremediably ill, and where the assistance is ‘clearly consistent with the patient’s wishes and best interests, and [provided] in order to relieve suffering’ (para. 358)(127).

Although the purpose of MAID is helping people to end suffering, the preservation of life principle stipulates that the way to end suffering should not be by terminating one’s life (Maravia 2021). Alternative solutions and support mechanisms should be used to eliminate or alleviate the suffering. As indicated above, in Canada, only persons aged 18 and above can apply for MAID. Although younger adolescents can consent in many medical interventions, restricting MAID to 18 years and above implies that the law makers avoid taking any risk of allowing adolescents to possibly make an emotional decision under the severe conditions of pain and hopelessness. As in other cases, when the medical intervention includes higher risks, the significance of competence also gets higher.

Taklif in Islamic law makes one responsible to God, which means accountability for themselves and at times others. A person’s body and soul are an amanah (trust) to themselves to protect and care for them. Thus, a mukallaf must make sure that their actions do not cost them their life. Adolescents as mukallaf in religious responsibilities would be guilty in front of God if they end their life, whether actively or passively.

Other maqasid al-Sharia objectives should also be carefully reviewed when adolescents are deciding about their health. Certain topics can be sensitive for those within Muslim families to decide on, such as treatments for drug addiction, sexual diseases, mental health issues, unwanted pregnancies, and gender-identity issues. When a related health care decision is needed, it should be handled carefully. Muslim families have different cultural backgrounds and biases affecting their religious understandings around these matters. Confidentiality surrounding medical topics in the Canadian sphere allows physicians to act responsibly in sensitive cases and protect
adolescents from possible harm. One of the principles in Islamic ethics, **preservation of children** (progeny), aims to protect children, or in other words, ‘entails everything essential to the welfare of the family’ (Abd-Allah 2012, 33). For instance, if an adolescent has a drug addiction and wants treatment, the physician can keep it confidential to protect the patient from reprisal, alienation and the like. A recent example of such application in literature is Akrami et al. (2022)’s work on the justification of at-risk adolescents’ access to key reproductive health services through applying Islamic legal maxims to the issue (230). However, if there is no risk of harm, the parents can be informed to provide support. Assuming all families would harm their kids could cause adolescents to miss the opportunity to receive the support they need in their struggle (Anderson 2015). If an adolescent suffers from mental health issues and is concerned regarding parents’ understanding, then two principles play a role in the decision-making mechanism: **preservation of children** and **preservation of intellect**. The latter principle aims to protect one’s ability to reason and conduct properly. Anything that interrupts reasoning, such as use of alcohol or other intoxicating drugs, is not allowed for that reason in Islamic law. Thus, if an adolescent suffers from a mental health issue, it needs to be cured. Another principle to be considered in medical decisions involving adolescents is **preservation of religion**. If an adolescent is offered a therapy which includes procedures that go against Islamic rules, that should not be ignored. For instance, if one is advised to take a vaccine which has porcine gelatin, its necessity should be carefully weighed to ascertain if it is darura (Padela 2010). If the adolescent’s life would be risked by not accepting that vaccine, then preservation of life would override preservation of religion.

**5.D. Guideline for ‘Questions to Ask’ in Adolescence Decision-Making Mechanism from Islamic Ethics Perspective in Canada**

As presented in the last chapter, adolescent medical decision-making is a complex issue due to the many factors at play and ambiguity regarding certain concepts.
The most difficult issue seems to be in determining ‘competence’ in order to decide if an adolescent can consent for medical interventions or research.

The diagram below demonstrates the possible questions to ask in approaching from an Islamic ethics perspective when an adolescent must decide regarding their health in Canada. These questions investigate several aspects, such as intentions relating to the intervention, potential benefits and risks of the procedure, adolescent’s competence, existing legislation if applicable, and the family’s role in the decision-making mechanism.
Figure 6. ‘Questions to ask’ from Islamic ethics perspective with adolescent individual involved in medical decision-making.

This diagram attempts to simplify the concerns in adolescent medical decision-making by pointing out the most frequent concepts and features appearing in our research. These questions can be used when an adolescent refuses a certain
intervention or considers joining a medical research. This diagram does not intend to suggest if an adolescent should be able to give consent in the end or not; however, it aims to utilize the information gained from the literature review in service of health care workers dealing with adolescents from an Islamic ethics lens. Questions regarding the intention of the intervention aim to understand if the intervention is initially developed to serve a daruri, haji, or tahsini need. Similarly, questions regarding the adolescent individual’s intention to consider that option aim to clarify if an adolescent’s choice is daruri, haji, or tahsini. The reason for this differentiation regarding the ‘intention’ is to ascertain: 1) the main purpose of the intervention, and 2) if the adolescent aims to benefit from the same purpose. For instance, bariatric surgery is a treatment method for severe obesity and resultant long-term ailments. However, for some adolescent patients, health concerns might not be the priority. Literature reviews on recent data regarding brain development of adolescents showed that they tend to perceive a reward value as higher than adults. When the reward is improvement in the body appearance, this might override concerns regarding the health benefit or risks for an adolescent. Austin et al. (2013) indicated:

At times, individuals who seek bariatric surgery lack motivation to make changes and rely solely on the surgery to reach goals of weight loss. This leads to difficulties with long-term weight loss and maintenance, so the bariatric team should address this early in the process with the patient and family. Knowledge deficits or maturity issues may prevent adolescent patients from seeing that a change is needed to protect health and well-being. Very few teenagers are motivated by long-term consequences of cardiovascular problems, increased cancer rates, pulmonary issues (asthma, sleep apnea), or other medical concerns. Instead, immediate, short-term rewards or consequences or internal thoughts and feelings about health often direct teen behavior (478).

One difference in approaching adolescent medical decision-making between current applications of clinical ethics and Islamic ethics is that Islamic ethics does not focus on prioritization of who decides in a medical situation when an adolescent, a caregiver and a health care worker are involved. The focus in Islamic ethics is first on the intention (of choosing certain medical interventions or similar), then what harm could
be expected from applying it and how it could be avoided or alleviated from the adolescent. Although adolescent autonomy is respected as well in Islamic ethics, that cannot be at the cost of their health. Rathor et al. (2016) stated, in situations when the patient’s choice risks their life or could lead to great harm, the Islamic principle of precaution regarding nonmaleficence overrides the patient’s autonomy (84-86). Otherwise, adolescents’ autonomy should be respected, and they should be included in the decision mechanism.

**Conclusion**

In our research, we aimed to tackle adolescent medical decision-making by dissecting the topic into distinct components and analyzing the concepts and issues in each part to be able to review the matter from an Islamic ethical perspective in the Canadian context. This process required delving into several disciplines such as Islamic theology, Islamic law, Canadian law, and developmental psychology. The concept of taklif as a core Islamic concept regarding moral/legal responsibilities facilitated discussing the issue from Islamic theology/ethics lenses. Islamic historical examples were presented to explore how adolescence was approached in the early Islamic period and modern period. Exploring recent information from developmental psychology was crucial to be informed with the most recent findings to make conclusions regarding adolescence competence in decision-making. Moreover, Canadian law regarding adolescents’ giving medical consent and decision-making practices in clinical ethics were reviewed to present the current legislations and applications in this matter.

In Islamic theology, taklif encompasses the rights, responsibilities, and charge of duty in Islamic law. The approaches of different schools of law differ in their understanding of taklif, particularly concerning the nature and role of free will. However, the importance of intellect, comprehension, and the capacity to fulfill responsibilities are emphasized in most of the views. Intellectual competence and
comprehension of the content play crucial roles in taklif, as individuals must possess the
capacity to bear its burdens and become responsible.

The term 'ahliyyat al ada' pertains to the competence that enables individuals to
exercise their rights and perform legal actions. It qualifies a person to make lawful
choices and accept the consequences of their actions. For example, the need for a
guardian or legal representative to enter into financial contracts indicates a lack of
ahliyyat al ada. This competence requires individuals to possess maturity in their
thinking, free will, and an understanding of the consequences of their actions. ‘Rushd’ is
related to ahliyyat al ada’ and refers to reaching maturity in intellectual capabilities,
which is substantial in making sound judgments and foreseeing risks in one's actions and
transactions. Different legal schools have varying criteria for judging mental maturity,
whether it be good character or diligence in transactional matters. Rushd resembles the
term ‘emancipated minor’ in Canadian law since both terms refer to young people with
financial awareness presenting a certain level of maturity. While "bulugh" refers to
sexual maturity and is relevant to liability, "rushd" is used to determine the age of
majority, especially in financial law. Reaching bulugh marks the beginning of religious
and legal obligations, and rushd is required for financial decision-making, involving
maturity in thinking and experience.

In the pre-Islamic period, age was considered significant for maturity, and elder
individuals held critical positions. However, in early Islam, major roles were given to
young members of the community. Adolescents such as Ali ibn Abi Talib and Mu'adh ibn
Jabal were assigned important responsibilities by Prophet Muhammad ﷺ. Scholars like
Imam Shafi'i and Imam al-Bukhari displayed exceptional abilities and began their
scholarly pursuits at young ages. Adolescents were appointed to key roles based on
their cognitive abilities and talents. Ottoman records show that adolescents had the
autonomy to make significant decisions (e.g. marital contracts). Royal adolescents in the
Ottoman Empire carried sizable responsibilities. Although these examples indicate that
adolescents commonly held higher responsibilities in early Islamic times, it is also
possible that some of the reported examples are unique, and those adolescents were
exemplary in their time. However, some scholars argued that there is a tendency in modern times to underestimate adolescents' maturity and thus assign them fewer responsibilities (Seise 2019).

A literature review on neurodevelopment showed that the adolescent brain undergoes changes in neurobiology and hormones, leading to emotional, cognitive, and behavioural adaptations. The prefrontal cortex (PFC) plays a key role in self-regulation and matures later in adolescence. Decision-making involves cognitive-control and socio-emotional systems, which are still developing in this stage. Risk-taking seems to increase due to adolescents valuing rewards as higher than adults, and their emotions can feature more prominently than with adults according to these findings. Thus, when adolescents are in a situation of making medical arbitrations, the possible factors affecting their decision-making should be reviewed carefully.

Medical decision-making is a complex mechanism which has shifted from a doctor-centered to a patient-centered approach in recent years, emphasizing autonomy and shared decision-making. Informed consent plays a crucial role, requiring patients to be well-informed about their condition and treatment options. Minors' medical decision-making in Canada is governed by three mechanisms: common law, provincial legislation, and child protection legislation. The mature minor doctrine allows children and adolescents to make their own medical decisions if they comprehend the nature and consequences of the procedure and if it is in their best interest. The age at which minors can consent varies among provinces, with some using fixed-age regulations while others use competence-based approaches.

Another noteworthy concept in adolescent medical decision-making is confidentiality. Consent and confidentiality are separate concepts, with confidentiality aimed at protecting the privacy of health information. Some argue that parents should be involved in providing important medical and family history, as well as helping adolescents understand treatment options. Others argue for adolescent confidentiality in promoting their development and control over their own information. In Canada, provincial regulations may take precedence in certain cases, and healthcare
professionals are responsible for judging the need for confidentiality or parental involvement based on the situation.

Finally, our literature review indicated that most studies on Islamic bioethics are based on fatawa, meaning the religious rulings in Islamic law (fiqh). A need exists for a systematic methodology and a more comprehensive attitude in Islamic bioethics, moving beyond the current heavily legalistic approach. Ramadan (2018) suggested that Islamic ethics should include philosophy (falsafah), theology (kala‘m) as well as mysticism (tasawwuf) besides law and jurisprudence (fiqh). He thought it necessary to include “Islamic philosophical and spiritual, as well as cultural, considerations” in Islamic ethics deliberations (1). It is also crucial to bring different perspectives and ethical concerns to the table to appreciate other possible ways of reviewing the issue. Hashmi (2021) criticized current Islamic bioethics research for not being inclusive and diverse. Moreover, he stated that Islamic bioethics should consider historical, cultural and social contexts prior to making conclusions (280-292).

After the literature review, the research question is reviewed following the principlist approach based on the Islamic ethics principles in light of recent progress in developmental psychology as well as clinical ethics approaches and Canadian law regulations. First, the ‘certainty cannot be overturned by doubt’ principle is used to review adolescent competence along with the ‘trusting reason’ principle in the axis of the ‘taklif’ concept. The review of the issue from this principle showed that adolescents should only be entrusted with decision-making authority if they have demonstrated cognitive development, competence, and the ability to comprehend the consequences of their choices. Our research acknowledges that adolescents are diverse, and their decision-making capacities vary. Thus, healthcare professionals dealing with Muslim adolescents should resort to several sources or indicators to judge adolescents’ maturity when assessing their autonomy such as financial awareness and responsibilities, comprehension of the medical intervention and previous experience with medical decision-making, and the family's opinion regarding the adolescent’s maturity.
The principle of ‘matters will be judged by their intentions’ emphasizes the importance of analyzing the intention behind the adolescent’s desired medical intervention to determine the ethical implications. Factors such as the necessity level of the intervention (daruri, haji, or tahhsini) and potential consequences should be considered when evaluating the risks of the decision.

The principles of ‘harm must be eliminated’ and ‘harm must be alleviated’ highlight the need to prioritize the well-being of the adolescent. In our research, adolescent medical decision-making is also reviewed from the ethical lenses of maqasid al-Sharia objectives. The prominent objective among the maqasid is ‘preservation of life’, which is prioritized over all other benefits. This principle also prevents adolescents from considering life-ending interventions through medically assisted methods due to the central role of the taklif concept in Islamic ethics. The person has responsibilities over their body and mind’s well-being to continue fulfilling their duties towards God.

The objectives to preserve religion, intellect, and children (or family) are also used to review adolescents’ medical decision-making. Preservation of children or family requires deliberate care in sensitive issues such as drug addiction, sexual diseases, mental health problems, unwanted pregnancies, and gender identity. Cultural backgrounds and biases within some families can influence their understanding of these issues. Canadian confidentiality laws allow physicians to responsibly handle such sensitive cases and protect adolescents. The Islamic principle of preserving children emphasizes safeguarding their welfare. For example, if an adolescent seeks treatment for drug addiction, the physician can maintain confidentiality to protect them from potential harm if they foresee certain risks.

Principles reviewed in this section emphasize the importance of assessing an adolescent's competence and intentionality, prioritizing their well-being, and making sure the decision will be for their ‘best interest’, evaluating the ethical implications of medical interventions. Moreover, while adolescents are in the process of deciding, protecting their intellect, safety/security, and religion/faith should be prioritized according to the Islamic ethics approach.
While these priorities are listed as guiding principles, we attempt to suggest a framework for ‘questions to ask’ in the process of adolescent medical decision-making. Although it has limitations and can be developed further for clinical use, it is resourceful in providing the tools and questions to guide the process. The questions investigate several aspects such as medical intervention in terms of the ‘intention’ and potential benefits and risks of a procedure, adolescents’ competence, existing legislation as applicable, and the family’s role in the decision-making mechanism. While judging the adolescent’s competence, it is also vital to ensure that adolescent persons do not decide based on emotions but also their critical thinking of the consequences.

In Islamic tradition, a good decision should be based on logic and not affected by emotions. However, as mentioned earlier, an adolescent individual can irrationally perceive reward value higher in situations where benefit and harm are involved. In a decision-making scenario, they tend to focus on rewards and underestimate harms and thus their decisions are more easily swayed by emotions. The Prophet Muhammad ﷺ said: “The judge should not issue a ruling between two people while he is angry.” (Sunan al-Tirmidhi 1334).

Although the possible factors surrounding adolescent decision-making are underlined in the literature review, further research is needed in the medical decision context to make conclusions. Our study is limited to a literature review and did not involve qualitative nor quantitative data based on the lived experiences of Muslim adolescents and health care workers. More research is needed to capture issues encountered in clinical settings. Moreover, our methodology was limited to the principlist approach in Islamic ethics. Adab literature was not included, although it is essential according to Sartell and Padela (2015) for a comprehensive approach. Further research combining these methods could facilitate a more holistic approach.


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**Curriculum Vitae**

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