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CASE REPORT

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Third-party refusal of medical treatment – a critical analysis of case report from Islamic ethical perspectives

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Abstract

Background Informed consent is a bedrock of ethical medical practice; however, scenarios in which a third party refuses life-saving treatment for an incapacitated patient present a unique and underexplored ethical quandary. Such conflicts are especially challenging when cultural or religious values influence decisions. In Muslim-majority contexts, healthcare practitioners often grapple with whether and how Islamic jurisprudence might justify overriding a guardian's refusal. While numerous case reports exist on patient-centred autonomy and consent, few specifically address the intersection of parental refusal, religious and ethical frameworks, and urgent clinical interventions. By examining this case and situating it within Islamic legal reasoning, we highlight a novel angle that offers healthcare providers religious insight and practical guidance.

Case presentation We present the case of an 18-year-old Muslim female with no prior significant medical history who arrived at the emergency department unconscious and in impending respiratory arrest. The clinical team recommended intubation to prevent critical deterioration. However, the patient's sole legal guardian—her mother—adamantly refused consent for endotracheal intubation and other potentially life-saving measures, including CPR, citing personal mistrust and past negative healthcare experiences. In response, the team adopted a less effective non-invasive ventilation strategy and pursued repeated discussions to understand the mother's rationale. Despite these efforts, the patient's trajectory only improved gradually without the recommended definitive intervention. The patient, once conscious, deferred decision-making entirely to her mother. Subsequent readmissions repeated this pattern of refusal and partial treatment acceptance. Ultimately, the patient recovered sufficiently for discharge, though underlying risk factors remained poorly addressed as she defaulted on her subsequent follow-up appointment.

Conclusions This case underscores the tension between guardian decisions, patient welfare, and religious-ethical principles. Our analysis reveals a principled basis for prioritising patient well-being over third-party refusal by examining Islamic jurisprudential rulings on consent. The insights from this case could inform more religio-culturally sensitive policies and strengthen clinical decision-making frameworks in contexts where religious norms significantly shape healthcare choices.

Keywords Third-Party Refusal of Treatment, Third-Party Consent under Islamic Law, Emergency Consent in Malaysia, Sharīʿah's Perspective of Patient Consent, Islamic bioethics, Guardian consent, Surrogate consent

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Introduction

Worldwide, informed consent is the cornerstone of medical practice from the perspective of law and ethics, which requires physicians to obtain written consent before initiating treatment. In emergencies, mainly when a patient is unconscious or incapacitated, this principle becomes more complex. Under Malaysian Medical Council (MMC) regulations, consent may be deferred for life-saving intervention only if no legal guardian or relative is available. However, a significant ethical dilemma arises when such a guardian is present but refuses care despite a patient's good prognosis. These refusals often stem from personal beliefs, past negative experiences with healthcare, or perceived religious obligations, which may clash with standard medical recommendations.

Malaysia is a Muslim-majority country where local culture and religious understanding are deeply entrenched in every aspect of daily life. While daily Islamic ritual practices are strictly observed, there are gaps in the knowledge of the non-ritual teachings of the religion, especially regarding medical practice. Islam, being a very structured belief system that encompasses every aspect of human life, is often misunderstood by common people who were not exposed to the nuances of the religious legal maxim and, at times, erroneously attribute ideas to Islam that may contradict established teachings.

Although quantitative data on third-party refusal in Malaysia are limited, the general incidence of discharge against medical advice attributed to the cultural and belief system has been reported in Malaysia and other countries [1, 2]. Anecdotal evidence from hospital ethics committees and many experiences from clinicians suggest that disputes involving relatives who refuse emergency or life-saving treatments for incapacitated patients are not isolated incidents. Complicating the matters is the tendency of the guardian to relate this to the religious teaching inaccurately. This inadvertently results in delayed interventions, increased morbidity, and potential medicolegal conflicts—factors that ultimately undermine patient safety and strain already burdened healthcare systems. Consequently, many clinicians turn to Islamic tradition (*Sharīʿah*) for guidance in such situations, aiding the clinical decision-making process and helping explain to the guardian. Such policies detailing how Sharīʿah-based principles apply to consent remain insufficiently articulated at the national level.

From a Sharīʿah perspective, crucial questions emerge: Can the refusal of lifesaving treatment by a guardian or relative be religiously justified if it risks severe harm or death to the patient? To what extent do Islamic legal maxims, such as the elimination of harm (*al-ḍarar yuzāl*), constrain or override a guardian's decision-making authority? These queries underscore the need for a clear Islamic framework that can be seamlessly integrated into existing legal and medical guidelines. Not only does this gap affect Malaysian healthcare practice, but it also carries broader relevance for other Muslim-majority nations navigating similar ethical quandaries.

To illustrate these challenges and offer preliminary guidance, this article presents a real-life case of a Muslim patient whose mother repeatedly refused recommended emergency interventions. By evaluating the scenario through a Sharīʿah lens—while acknowledging general bioethical principles—we aim to equip physicians, ethicists, and policymakers with a more robust foundation for resolving third-party refusal cases. Ultimately, we strive to harmonise patient welfare with deeply held religious values, ensuring that medical and moral imperatives are fulfilled.

Case report

An 18-year-old female with no prior established medical problem was brought to the emergency department (ED) unconscious and in impending respiratory arrest. After stabilising her, the managing team recommended intubation to prevent further deterioration. However, her mother, a divorcee and the patient's sole legal guardian, refused consent despite multiple consultations explaining the critical nature of the intervention. The mother remained resolute, signing a document formally declining the treatment and expressing her preference to withhold life-saving measures, including CPR, should cardiac arrest occur.

The mother expressed strong reservations about medical interventions, believing that her daughter's immune system was sufficient to fight infections without antibiotics. She was also sceptical about the urgency of interventions, questioning whether the medical team had prematurely diagnosed lung and renal failure. She further attributed her daughter's drowsiness to high-flow oxygen therapy rather than the underlying illness, requesting its discontinuation.

As a compromise, the medical team initiated non-invasive ventilation, a less effective alternative. Throughout the admission, repeated efforts were made to understand the mother's perspective and persuade her to reconsider, but these attempts were unsuccessful. The patient's condition gradually improved, and upon regaining consciousness, she deferred all decisions about her care to her mother. After a 13-day hospitalisation, she was discharged.

Two days later, the patient was readmitted with a recurrence of her respiratory condition. Again, the mother dictated the terms of her daughter's care, including specific instructions on medications and life-saving limitations. It was revealed during this period that the mother, who

homeschooled the patient and her three siblings, was the sole caregiver, with no involvement from the father.

From the initial admission, the managing team engaged in repeated discussions with the mother, involving emergency medicine, internal medicine, anesthesiology, and the ethics committee, explaining the necessity of life-saving interventions. Despite their efforts, she insisted on a selective treatment approach, declining intubation and intravenous antibiotics while agreeing only to oxygen support, fluids, and limited medications. Recognising the trust deficit, the team adopted a stepwise approach, initially using non-invasive ventilation as a compromise. However, the patient's readmission and worsening condition highlighted the risks of this approach.

Fortunately, after 21 days of hospitalisation, the patient gradually improved and was discharged. However, due to her severe obesity and high risk of recurrent complications, a follow-up plan was arranged, but the patient failed to attend scheduled appointments.

The general medical ethics perspective

From the general medical ethical perspective, third-party consent refusal can be highly problematic, especially when the decision exposes the patient to critical harm. This issue is complex, as it involves balancing the autonomy and rights of the patient. Patients who have the capacity to make decisions are permitted to refuse treatment, provided they fully understand the consequences of their choice. However, when third parties are involved, it is crucial to assess the decisions made to ensure they are in the patient's best interests, mainly to avoid any harmful effects that could worsen the patient's condition. It is essential to understand that a third party's authority to refuse treatment on behalf of a patient is often limited, as they must prioritise the patient's best interests [3, 4].

Reflecting on the case above, it becomes clear that the mother's decision poses significant risks to the patient's medical condition. Without appropriate and timely medical intervention, the patient's health may worsen, potentially leading to preventable complications or even death. The mother's refusal to allow necessary treatments seems to be based on her valid concerns regarding the associated risks, a general mistrust of the healthcare provider, and her own previous negative experiences with medical care. These factors may have contributed to her apprehension and hindered her willingness to accept medical recommendations. It is crucial to delve deeper into the reasons behind the mother's refusal.

Respecting the mother's decision is vital for maintaining a harmonious decision-making process; however, the core issue revolves around the patient's health and well-being. Recognising that the patient has an inherent right to receive essential medical treatment, mainly when such treatment is likely to yield positive health outcomes, is crucial and fundamental based on the ethical principle of the patient's best interest, beneficence and justice.

Additionally, the mother's refusal to consent to treatment raises concerns, as it appears to deviate from the typical behaviour expected of a parent who prioritises their child's best interests. This prompts a thorough investigation into the reasons behind the mother's decision. Understanding her motivations is essential, as it could reveal misunderstandings, fears, or misinformation influencing her choice.

Sharīʿah's perspective

Consent is an integral element in any social relation (*muʿāmalah*) under the Sharīʿah. This includes various non-economic and economic activities, including marriage and seeking medical treatment. The consent requirement is indispensable, without which the contract will be declared null and void. The case above illustrates the importance of understanding this element and the nuances surrounding the case. Delving further, several other aspects also shall be considered from the Sharīʿah perspective, including the original ruling on seeking treatment, the types of illnesses for which treatment may be refused, the ruling on obtaining consent from the patient, the issue of refusing or consenting treatment on behalf of another person, and the rights of parents and guardians in determining a child's treatment.

The general principle of derivation of Islamic Law

Islamic scholarship was developed over centuries through engagement with primary Islamic sources—the Qur'ān and Sunnah (prophetic tradition)—along with rational inquiry, legal methodologies, and philosophical discourse. Through a structured process known as *ijtihād*, classical jurists perform an inductive analysis of various rulings in different fields, identifying consistent themes and patterns that can be formulated as overarching principles [5]. These maxims often crystallise as concise statements, such as "Actions are judged by intentions" and "Harm must be eliminated" [6, 7]. Hierarchically arranged with five core axioms at the top and numerous corollaries beneath, they help jurists remain faithful to primary texts while adapting rulings to evolving social contexts [8, 9].

An integral part of deriving maxims involves aligning them with the overarching objectives of Islamic law (*maqāṣid al-sharīʿah*): preserving religion, life, intellect, lineage, and wealth. In medical ethics, for instance, the principle of saving life (*nafs*) helps justify the maxim "Necessity renders prohibited acts permissible" by allowing organ transplantation in life-threatening situations. Likewise, "Custom is a basis for judgment" (*al-ʿādah*

muḥakkamah) ensures the Sharīʿah remains relevant to contemporary norms, ranging from digital financial transactions to novel medical procedures. By weighing these universal objectives against specific scenarios, jurists can balance textual fidelity and practical realities [10–12].

In addition to aligning rulings with the *maqāṣid,* jurists also observe in applying the element of *adab,* defined loosely as the moral compass and spiritual ethos that animates the entire legal framework, ensuring that legal rulings align with the Qurʾānic call for upright conduct and excellence in character. While the element of adab in Islam is deeply rooted in Qurʾānic teachings and prophetic traditions, it shares many ethical principles with non-Islamic traditions**,** particularly in the field of medicine.

The adab of medicine emphasises ethical conduct, compassion, and professional integrity, closely aligning with the four fundamental Western medical ethics principles—autonomy, beneficence, non-maleficence, and justice. It also requires physicians to uphold mercy (*rahmah*), treat patients with dignity and respect (*karāmah*)**,** and prioritise well-being (*maslahah),* similar to the Hippocratic Oath and contemporary bioethics. Islamic medical ethics, as reflected in works like Ibn Sina's (d 1037 CE) *Canon of Medicine* and al-Ruhawi's (fl 9th. CE) *Adab al-Tabib* (Ethics of the Physician)**,** emphasise humility, honesty, and patient-centred care—principles that resonate with modern medical professionalism. Both traditions advocate for ethical decision-making, the duty of care, and the physician's responsibility to uphold the trust of society [13].

Historically, four major Sunni schools—Ḥanafī(d 767 CE), Mālikī(d 795 CE), Shāfiʿī (d 820 CE), and Ḥanbalī(d 855 CE) —have each refined and applied these legal maxims through their respective methodologies. In Malaysia, the Shāfiʿī school is officially predominant; however, local jurists often exercise *takhayyur* (pragmatic selection) by drawing upon positions from other schools when an issue remains unresolved under existing national rulings [14]. Should ambiguities persist, scholars may consult reputable international fiqh bodies such as the Majmaʿ al-Fiqh, which issue contemporary rulings on complex subjects like IVF, end-of-life care, or stem-cell research. Ultimately, the final authority rests with the local Majlis Fatwa, which tailors global juristic opinions to Malaysia's sociocultural context.

The original ruling on seeking treatment

Scholars have differing views on the original ruling regarding seeking treatment—whether it is obligatory (*wajib*), recommended (*sunnah*), permissible (*mubah*), or discouraged (*makruh*). The majority of scholars are of the opinion that the original ruling on seeking treatment is permissible, not obligatory. Ibn Abd al-Barr(d 1071 CE), a scholar from the Maliki school, stated:"Some scholars from the generations of the *salaf* (the first three generations of Muslim) and *khalaf* (the generations after salaf) patiently endured their illnesses until Allah cured them, despite the availability of doctors. No scholar criticised their decision not to seek treatment. If seeking treatment were obligatory, then scholars would have criticised and reprimanded those who refrained from it. However, the fact remains that no one criticised this action. Thus, the original ruling on seeking treatment is not recommended or obligatory, but permissible, as held by the majority of scholars"[15, 16]. Al-Dhahabi (d 1348 CE) cited this view as being supported by consensus by Muslim scholars (*ijmāʿ*) [17].

However, some scholars from the Ḥanafī, Shafi'i, and Ḥanbalī schools argue that seeking treatment becomes obligatory in cases where failure to seek treatment could lead to significant harm, such as disability or death. Al-Qaradawi (d 2022 CE) [18], al-Qarah Daghi (living), and al-Muhammadi (living) [10] note that the classical view of seeking treatment as non-obligatory was influenced by the lower probability of recovery in earlier medical practices. In contrast, the improved success rates of modern medical treatments make seeking treatment more necessary in today's context. This position is also supported by the resolution of the International Islamic Fiqh Academy (IIFA) [12], which affirmed that seeking treatment is obligatory if failing to do so would lead to significant harm or death.

Consent from Sharīʿah's view

The importance of medical consent could be clearly derived from a *hadith* narrated by 'Aishah(RA) in which she and several companions administered medicine to the Prophet despite his explicit refusal**,** conveyed through a non-verbal signal while he was still conscious. His companions, interpreting his refusal literally, refrained from administering the medicine at that moment. However, when the Prophet later became unconscious or fainted**,** they proceeded to administer the medicine, assuming that his initial refusal was due to his weakened state rather than an informed decision. Upon regaining consciousness, the Prophet discovered that medicine had been placed in his mouth against his expressed wishes. In response, he became displeased and ordered that those involved in administering the medicine undergo the same treatment as a form of reciprocation [19, 20]. This hadith underscores the fundamental principle of informed consent in medical ethics**,** emphasising that a patient's refusal of treatment must be respected, even if expressed through non-verbal cues. Additionally, it emphasizes that

consent does not always require written documentation, but it must be clearly understood and acknowledged before any intervention occurs [21].

From the earliest days of Islamic civilisation in the seventh century CE, Sharīʿah has required a contractual agreement (*ʿaqd*) between patient and healthcare provider—well before modern Western notions of informed consent gained formal recognition in the twentieth century [22].

Classical jurists characterise medical treatment contracts under *ʿaqd ijārah* (a lease-type agreement) or *ʿaqd ʿamal* (an employment contract), both necessitating mutual consent and clarity regarding the scope, risks, and expected outcomes of any procedure [23, 24]. This emphasis on contract aligns with the fundamental principle that "no one may use another person's property or violate their rights without the rightful owner's permission," which applies even more strictly to bodily integrity [22].

Capacity (*ahliyyah*), as defined by Imām al-Rāzī (d 1209 CE), is the "capability for being obliged to legitimate rights and duties," and the Sharīʿah makes no distinction between men and women in their ability to provide consent once capacity is established [24, 25]. Should capacity be lacking—whether due to age, unconsciousness, or mental impairment—the responsibility for giving consent transfers to a legal guardian. In line with inheritance rulings, classical jurisprudence typically places guardianship authority with a male relative. Imām al-Shāfiʿī (d 820 CE) illustrates the importance of valid guardianship by stating: "If a man brings a boy to a doctor to be circumcised, but the boy is not his son or under his guardianship, the doctor must pay compensation for any harm caused" [26].

Modern fiqh bodies such as the International Islamic Fiqh Academy (IIFA) reinforce these principles, stipulating that consent is valid only if given by a patient in full legal capacity or otherwise by a legitimate guardian who must act in the dependent's best interest [12]. By synthesising classical rulings with current legal resolutions, Islamic jurisprudence provides a framework that both respects the sanctity of human autonomy and recognises necessary guardianship roles in contemporary medical settings.

Autonomy

The concept of consent under the Sharīʿah implies the Islamic legal maxim of respecting individual autonomy. However, in contrast to the Western medical ethics concept of total individual autonomy, the Sharīʿah views the position of autonomy as being guided by God's revelation through the Qur'ān, ahādīth and scholarly opinion [27]. Although there is a spectrum of rulings, the ultimate decision shall come from the individual him/herself based on the condition specific to him/herself. That as it may, the flexibility of the decision is restricted to oneself and shall not be extended to other people under his/her guardianship. In this condition, the concept of necessity and the patient's best interest based on the assessment of the managing doctor overrides the autonomy of the guardian.

The Islamic legal maxim of harm elimination

Islamic law places great emphasis *on al-ḍarar yuzāl* (harm must be eliminated). This core maxim upholds the sanctity of life and mandates the removal or prevention of serious injury whenever possible [28]. In cases of third-party refusal, this principle interacts with the patient's right to medical treatment in a pivotal way: where refusal prolongs or escalates harm; it violates the Sharīʿah-based imperative to "cause no harm and prevent harm" (*lā ḍarar wa lā ḍirār*). Consequently, while family autonomy and consent are respected in Islamic ethics, they do not extend to perpetuating or enabling harm—particularly when urgent, life-saving interventions are at stake. In practice, if a patient's legal guardian withholds consent in a manner that imperils the patient's life, healthcare professionals have both a moral and Islamic legal mandate to intervene because allowing preventable harm contradicts the overarching duty of *ḥifẓ al-nafs* (preserving life) and the obligation to eliminate injury.

Further, the broader system of Islamic legal maxims clarifies how to negotiate competing interests when harm seems unavoidable. For instance, the maxim "repelling evil is preferable to securing benefit" (*darʾ al-mafāsid awlā min jalb al-maṣāliḥ*) demands that doctors avert the grave harm of a potentially fatal outcome—even if it means temporarily overriding the surrogate's or parent's autonomy. Another relevant principle is "major harm is removed by lesser harm," signifying that restricting a guardian's refusal (the "lesser harm") is warranted when it protects the patient from a far greater harm (such as death or severe disability). Ultimately, these maxims harmonise the respect for autonomy with the categorical imperative of safeguarding life, ensuring that any decision-making authority is anchored in the ethical and legal duty to eliminate harm rather than allow its continuation.

Consent from Guardian

Scholars hold divergent views on the primary right to grant medical consent as a guardian**,** reflecting varying interpretations within Islamic jurisprudence. These perspectives can be categorised into four distinct positions.

The first view**,** upheld by the Maliki [29] and Ḥanbalī [30] schools of thought, asserts that the right of guardianship first lies with the father, followed by the recipient

of his will and, subsequently, the judge or ruler. This hierarchy is grounded in several arguments. First, a child is considered a divine trust bestowed upon the father, rendering him the most deserving guardian [30]. Second, the father's profound love and responsibility for his child position him as the most suitable protector [30]. Third, upon the father's demise, the designated will-recipient assumes guardianship, functioning as his legal proxy, akin to how a representative acts on behalf of the father during his lifetime [30–32]. Finally, the judge or ruler is regarded as a guardian for those without one, a principle derived from a hadith narrated by ʿAishah (RA), which affirms that the ruler assumes responsibility for individuals lacking a direct guardian [33].

The second view, advocated by the Shafiʿi [34, 35] school and supported by a narration within the Ḥanbalī tradition [30], outlines a different sequence of guardianship: the father, followed by the paternal grandfather, then the surviving heir, and ultimately, the judge. This position equates the paternal grandfather's authority with that of the father, as both share the status of 'fathers' in lineage [30]. This reasoning is substantiated by the Qur'anic verse in Surah al-Hajj (22:78), which refers to Prophet Ibrahim (AS) as a 'father' despite the vast generational gap between him and the Prophet Muhammad (PBUH). Such an analogy reinforces the notion that the paternal grandfather holds equal custodial rights as the father [36].

The third view, primarily associated with the Ḥanafī school [37–39] and supported by al-Shinqiti (living) [40], aligns guardianship with the principles of inheritance (*'asabah*). Under this framework, the sequence follows the closest heir, beginning with the son, then the father, followed by the paternal grandfather, and subsequently the other male heirs. This interpretation is rooted in the premise that guardianship should correspond with inheritance rights, as those with the strongest legal ties are presumed to possess the greatest emotional attachment [37]. However, this position has been critiqued for its exclusion of the mother, whose maternal affection is often considered stronger than that of the male heirs [41].

The fourth perspective, championed by Abu Saʿid al-Istirakhi al-Shafiʿi [34, 35], a narration from the Ḥanbalī school [42], Ibn Taymiyyah (d 1328 CE) [43], and Hani al-Jubair (d CE) [41], presents a more contemporary approach. This view reorders the hierarchy of guardianship, placing the father first, followed by the paternal grandfather, then the mother, and finally, the closest heir based on *'asabah.* This approach recognizes the evolving realities of familial relationships, arguing that close relatives, particularly the mother, are better positioned to make informed decisions about medical care, as opposed to will recipients or judicial authorities, who may lack an intimate understanding of the patient's needs.

These varied perspectives illustrate the nuanced juristic discourse surrounding medical consent within Islamic law. While classical jurisprudence prioritizes paternal guardianship, contemporary interpretations acknowledge the need for flexibility, particularly in modern healthcare contexts, where maternal and familial roles play a critical part in decision-making. The evolving nature of guardianship discussions underscores the adaptability of Islamic legal principles, ensuring that ethical considerations remain aligned with the welfare and best interests of the patient.

The Role of Guardian in 3rd-Party Consent

As described above, the role of consenting or refusing medical treatment is restricted and shall be in the best interest of the patient. This is alluded to in the subsequent description of the same IIFA resolution [12]: "If the guardian, however, does not give consent, his decision shall not be taken into consideration if it is clearly detrimental to the person under guardianship. The right to giving consent shall then be transferred to the next guardian and ultimately to the authorities." This is further enhanced in the other resolution of IIFA for emergency surgery: "If the patient is not in his full capacity and consciousness and his guardian refuses to give permission for his treatment while medical treatment is urgent, refusal of guardian should be ignored and right of permission shifts to public guardianship represented by its competent …".

Based on the above argument, for this reported case, the mother's refusal to allow the doctors to provide treatment to her child shall be perceived as invalid from a Sharīʿah perspective. The additional reason for this is the Sharīʿah's view on the legal positioning of the mother as the guardian. Although the mother was recognised as the legal guardian by civil law, this is not in tandem with Sharīʿah, which states that the legal guardian is typically the father and others according to the prescribed order of guardianship. Even if the mother is acting as a representative (*wakīl*) of the child, she must base her decisions on the best interests of the child, guided by the managing doctors. If the child has reached the age of being able to make decisions and at full capacity, the preferences of the child should also be taken into consideration. This is alluded to in a hadith narrated in Ṣaḥīḥ al-Bukhārī, which recounts how the Prophet Muhammad (SAW) rebuked his companions for administering medicine to him while he was unconscious despite his earlier instructions not to do so. This highlights the importance of following the expressed wishes of the person being represented [19, 20].

Finally, the mother's stand contradicts the basic principles of Islamic law, which prohibits actions that harm others. Even if the mother followed the classical view that seeking treatment is not obligatory, she would still be obligated to seek treatment for her child, as neglecting it could lead to harm [18]. Seeking treatment also becomes obligatory when the disease is contagious and could harm others, as was the case during the COVID-19 pandemic [44–46]. The overarching priority for guardianship under Islamic law is the aspect of welfare. The fiqh principle states: "Decisions regarding a dependent must prioritise their welfare" [9]. The IIFA resolution further emphasises that a guardian's harmful decision can be overridden. Doctors shall consider the mother's wish, but the ultimate decision shall be based on the principles described above.

Conclusion

This case highlights a complex moral landscape where third-party refusal of medically indicated treatment conflicts with the patient's best interests. From an Islamic perspective, while autonomy and consent are valued, they are not absolute when the patient's life or well-being is at stake. Islamic jurisprudence supports overriding a guardian's refusal to ensure essential care, aligning with fundamental bioethical principles such as beneficence and non-maleficence.

For Malaysia and similar contexts, this suggests the urgent need for clear clinical guidelines that respect religious values yet affirm the priority of patient welfare. Although they may not need to be legislative, the guidelines should be persuasive for Muslims. By establishing transparent policies for surrogate decision-making and involving Islamic scholars, ethicists, legal experts, and clinicians, such frameworks can navigate these ethical dilemmas more effectively. Ultimately, integrating Islamic legal principles with international ethical norms will help safeguard patient rights and health, ensuring that both moral and medical duties are met.

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MI is involved in the conception and design, provision of study material, and collection and assembly of data. MIKM, MNH and ANMY are involved in the manuscript writing. All authors approved the final manuscript.

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Data availability
Data are available from the authors upon reasonable request and with permission from the Hospital As Sultan Abdullah, Malaysia.

Declarations

Ethics approval and consent to participate
This is a write-up based on a case study with no patient identifier, and no ethical approval is required.

Consent for publication
Written informed consent was obtained from the patient's next of kin for this case report. All potentially identifying information has been removed to protect the patient's privacy.

Competing interests
The authors declare no competing interests.

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