

Islam and Biomedical Ethics

with Mohammed Ghaly, "Islamic Bioethics in the Twenty-first Century"; Henk ten Have, "Global Bioethics: Transnational Experiences and Islamic Bioethics"; Amel Alghrani, "Womb Transplantation and the Interplay of Islam and the West"; Shoaib A. Rasheed and Aasim I. Padela, "The Interplay between Religious Leaders and Organ Donation among Muslims"; Aasim I. Padela, "Islamic Verdicts in Health Policy Discourse: Porcine-Based Vaccines as a Case Study"; Mohammed Ghaly, "Collective Religio-Scientific Discussions on Islam and HIV/AIDS: I. Biomedical Scientists"; Ayman Shabana, "Law and Ethics in Islamic Bioethics: Nonmaleficence in Islamic Paternity Regulations"; and Willem B. Drees, "Islam and Bioethics in the Context of 'Religion and Science'."

THE INTERPLAY BETWEEN RELIGIOUS LEADERS AND ORGAN DONATION AMONG MUSLIMS

by Shoaib A. Rasheed and Aasim I. Padela

Abstract. Bioethics and health researchers often turn to Islamic jurists (fuqahā') and their verdicts (fatāwā) to understand how Islam and health intersect. Yet when using fatāwā to promote health behavior change, researchers have often found less than ideal results. In this article we examine several health behavior change interventions that partnered with Muslim religious leaders aiming at promoting organ donation. As these efforts have generally met with limited success, we reanalyze these efforts through the lens of the theory of planned behavior, and in light of two distinct scholarly imperatives of Muslim religious leaders, the 'ilmī and the islahī. We argue for a new approach to health behavior change interventions within the Muslim community that are grounded in theoretical frameworks from the science of behavior change, as well the religious leadership paradigms innate to the Islamic tradition. We conclude by exploring the implications of our proposed model for applied Islamic bioethics and health research.

Keywords: bioethics; fatwa; health care; Islam; medical ethics; Muslims; organ donation; theory of planned behavior; Ulama

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A review of the literature on organ donation and transplantation among Muslims reveals that Muslims are more likely than people of other faiths to have a negative attitude toward organ donation (Rasheed 2011). Study after study demonstrates two overarching themes: first, Muslims are frequently uncertain whether organ donation is permissible or forbidden according to the Islamic ethico-legal tradition, and second, even in the cases where the Muslim laity believes donation to be permissible, this knowledge does not lead to actively supporting organ donation through actions such as signing a donor card (Rasheed 2011). This observation has led to the implementation of numerous health behavior change interventions that aim to increase organ donation rates among Muslims by targeting perceived religious impediments to donation.

One may argue that there is no direct relationship between being Muslim and having negative attitudes toward donation, and that the negative attitudes seen in the literature are completely attributable to indirect, nonreligious factors such as acculturation, education, health literacy, and sociodemographics. It may be, for instance, that Muslims have negative attitudes toward donation because they are not English-literate, and therefore do not have access to much of the literature that explains organ donation processes to the lay population.

While nonreligious factors such as the aforementioned do influence attitudes toward organ donation and transplantation, they cannot explain Muslim attitudes entirely. Existing survey research involving diverse Muslim groups shows that religious affiliation, namely identifying with Islam, is associated with negative attitudes toward, or lack of support for, organ donation and transplantation. These studies have been conducted among ethnically and racially diverse groups of Muslims and in diverse sociocultural settings such as the United Kingdom (Randhawa 1998; Sheikh and Dhimi 2000; Alkhawari et al. 2005), Malaysia (Loch et al. 2010), Saudi Arabia (Shaheen et al. 1996), Turkey (Bilgel et al. 1991; 2004), and the United States (Padela et al. 2010a).

This growing body of literature suggests that a global “Muslim” phenomenon cannot be attributed to socioeconomic factors entirely. Given that these studies document similar findings among Muslims who come from diverse socioeconomic and cultural backgrounds, live in societies that vary in political and healthcare system structures, and face different social and health challenges, the literature suggests that something that they all share influences their similar attitudes. According to many researchers, that common epidemiological factor is religion-related. Indeed, an increasing amount of research shows that Islam influences Muslim health behaviors across racial and ethnic lines (Padela and Curlin 2012). Bolstering the evidence for a “religious” influence upon Muslim behaviors related to organ donation is the fact that being Muslim often appears to be independently associated with negative attitudes toward donation. In other words, some

of the aforementioned surveys report that even when the influence of sociodemographic factors is accounted for, through multivariate regression modeling for example, affiliation with Islam continues to predict negative attitudes toward organ donation.

One example of a study that illustrates this phenomenon analyzed a population-based representative sample of 1016 Arab Americans. Data analyses revealed that Muslim participants were significantly less likely than Christian participants to find organ donation after death to be justified, even after the effects of factors unrelated to religious affiliation such as age, educational attainment, level of income, and gender were controlled for (Padela et al. 2010a). Similarly, another study that surveyed 904 Malaysians identified being Muslim (as opposed to Hindu) as a significant factor associated with reluctance toward donating one's organs after death. Multiple logistic regression analysis confirmed that this factor was independently associated with attitude toward organ donation (Loch et al. 2010). Therefore, while nonreligious factors certainly play a role and merit further study, it seems that there is clearly something about being Muslim *in and of itself* that leads to negative attitudes toward organ donation.

In light of the apparent suspicion with which Muslims from across the globe view organ donation, one may presume that the Islamic ethico-legal tradition judges organ donation to be either forbidden or discouraged. Such a presumption is, however, unwarranted. The majority of *fuqahā'* and ethico-legal councils deem organ donation and transplantation to be ethico-legally permissible.¹ Prominent among this group are the five former grand *muftīs* of Egypt, the Saudi Senior Ulama Council, the Islamic Fiqh Academy of the Organization of the Islamic Cooperation, the Turkish Supreme Board of Religious Affairs, and the European Council for Fatwa and Research. Others such as the Islamic Fiqh Academy of India hold cadaveric donation to be forbidden, but still allow transplantation from living donors. Only a small minority of *fuqahā'*, the late Grand *Muftī* Muḥammad Shafi' of Pakistan being the most notable among them, consider the practice prohibited absolutely by Islamic law (Ghaly 2012a; Rasheed 2011).

For health behavior interventionists working to improve Muslim donor rates, this poses a conundrum: how do we reconcile the lack of support that organ donation has among the Muslim laity with the apparent green light that the *fuqahā'* have given the practice? Improving Muslim donor rates requires addressing this puzzling observation. While there have been a great many programs aiming to increase the support for organ donation in Muslim communities, and thereby increasing donor rates among Muslims, we suggest that these efforts have missed the mark because they overlook the theological motivations that categorize Islamic religious leaders. Consequently, the theoretical frameworks that implicitly, or explicitly, guide health behavior interventions incorporating Muslim religious leaders often neglect a key group of religious actors, the representatives of a particular

Islamic theological imperative, that must be partnered with when seeking to effect health care behavior change among Muslims.

In this article, we will highlight some key assumptions underlying the theoretical frameworks behind many health behavior change interventions up till now. We will then reevaluate these assumptions in light of the theory of planned behavior (TPB), a leading conceptual theory used to organize health behavior change interventions. We will subsequently link the TPB to the theological motivations of Muslim religious leaders as a way to draw attention to a neglected key group of religious actors: representatives of what we identify as the *islāhī* imperative in these interventions. This group of on-the-ground religious guides includes, most prominently, the *imāms* of local mosques and Islamic centers. We argue that for future interventions to be successful, this group must be engaged when seeking to effect health care behavior change among Muslims, and that this lack of partnership is a common characteristic of health behavior change interventions that have thus far been conducted.

INTERVENTIONS TO DATE

Bioethics researchers and health behavior interventionists have most often partnered with the *fuqahā'* to overcome Muslim reticence toward organ donation, and concerned themselves mainly with *fatāwā* that these *fuqahā'* had penned. The theoretical framework of these interventions was based upon the assumption that the negative attitudes of Muslims at the ground level were on account of either (1) a lack of awareness about the religious decrees (*fatāwā*) that permitted organ donation and transplantation, or (2) the lack of supportive "local" *fatāwā* penned by *fuqahā'* who were native to, and familiar with, the indigenous societal contexts (and thereby more likely to be trusted and accepted by the local Muslim community).²

One example that illustrates these assumptions is found in the Saudi Center for Organ Transplantation. The Center conducted several studies regarding the effect of being Muslim on public attitudes toward organ donation and transplantation. An examination of these studies reveals the underlying premise that the vast majority of *fuqahā'*, and in particular the Saudi-based Senior 'Ulamā' Council, support donation. Hence, public objections to transplantation must arise from a lack of awareness about these decrees. For instance, one study writes:

The public should be well informed on the religious aspects of organ donation. This was reflected in the results where in 27.5% of the respondents refused the concept of organ donation due to religious reasons. Uniformity and consistency on the information of the religious aspects of organ donation through the approval of the fatwa [the author is referring to the Saudi Senior Ulama Council's *fatwā* that permits donation] is very important in Saudi Arabia, since most people abide by Islamic law and reject any intervention that is forbidden by Islam. (Alam 2007)

This passage demonstrates both of the aforementioned assumptions. It asserts the connection between the study participants' refusal to donate with their lack of awareness of the *fatāwā* that permit donation. It also puts emphasis on the Senior 'Ulamā' Council's *fatwā* in particular, because of the assumption that the views of indigenous *fuqahā'*, with their familiarity of their society's context, will resonate best with the local population.

Implicitly, then, the *fatwā* was seen as an instrument for health behavior change. The corollary assumption is that if a Muslim knows that the Islamic ethico-legal tradition permits a certain practice, he or she will then be more willing to support, and engage in, that practice. Illustrating this type of interventional model and the underlying assumptions about Muslim religious leadership and *fatwā*, Turkish researchers carried out an educational program where participants attended "teach-ins" that aimed to dispel common myths and understandings about organ transplantation (Yilmaz 2011). One of the primary lessons was structured around presenting participants with *fatāwā* that permit organ transplantation issued by several Islamic ethico-legal bodies including the Turkish Supreme Board of Religious Affairs.

If we move from the Muslim majority context to one where Muslims are in the minority, we see that the same role of *fatāwā* is assumed. An example of this is where British researchers from the Birmingham Organ Co-ordination Team collaborated with the UK Muslim Council to address lower rates of Muslim participation in the UK organ donation programs. The collaboration resulted in the UK Muslim Council, comprising nineteen prominent British *fuqahā'* and religious leaders, passing a *fatwā* that judged organ donation to be permitted in Islam (Badawi 1995). Public health leaders "considered [the program] a success and a step forward," believing that "it would lead to a breakthrough in resolving the problem of low donor rates among Muslims" (Razaq and Sajid 2007). Nine years later, however, a follow-up study of Muslim donor rates revealed that Muslim donor rates in the region had not significantly increased since the passage of the *fatwā*. The medical community's disappointment with this collaborative effort, and the *fatwā* by extension, is apparent as authors note that the initiative had "fallen flat," "in spite" of the outreach efforts of the community health workers (Razaq and Sajid 2007).

From this examination, we learn that the theoretical framework behind previous health behavior change interventions rested upon assumptions that center around the *fatwā*, and they often attempted to use the *fatwā* as an agent to change health behavior. It seems, however, that these *fatwā*-centered interventions tend to be unsuccessful. In the case of the British intervention involving the UK Muslim Council, Razaq and Sajid write that "perhaps a more harsher [sic] regime has to be enforced, whereby the Muslim community is advised that organ transplantation can only be offered as an option to them if they are willing to become a donor" (2007).

Before resorting to these measures, however, perhaps this lack of success can be explained upon a closer examination of the theoretical framework behind the interventions (this framework is summarized in Figure 1, and explained in detail in the sections that follow).

THEORETICAL FRAMEWORK

According to the TPB, the most important predictor of whether people will perform a certain behavior is if they have an intention to perform that behavior (Ajzen 1991). In terms of the topic at hand, the behavior changes most pertinent may be, for instance, that someone registers to be an organ donor. According to the TPB, the best predictor for whether or not that person actually signs up would be whether they made an intention to do so. According to TPB, one's behavioral intention is informed by: (1) one's overall *attitude* toward the action, including his or her expectations of the outcomes associated with the action; (2) one's belief that most of the people important to him or her believe that he or she should or should not perform the action (known as *subjective norm*) and beliefs about those norms; and (3) one's *perceived control* over performing the action. In other words, the *Attitude* refers to an overall view a person holds toward a specific action. The *Subjective Norm* refers to an individual's summative evaluation as to whether all of his important others (i.e., family, friends, mentors, role models, society at large) approve or disapprove of his performing the action. And *Perceived Behavioral Control* refers to the perceived ease or difficulty of performing the action (Ajzen 1991).

To apply this in the case of organ donation and transplantation, the TPB explains that Muslims will be more likely to donate their organs or sign a donor card if they have a strong intention to do so. This intention to donate is determined by three factors: (1) they must have an overall positive attitude toward donation; (2) they must believe that the individuals or entities most important to them have a favorable view toward their donating their own organs; and (3) they must perceive themselves to have substantial control over donating their organs.

Each of these three determinants to intention (*Attitude*, *Subjective Norm*, and *Perceived Behavioral Control*) has two other subdeterminants. We will focus on *Subjective Norm* because it is the most pertinent determinant of the three for the discussion that follows. *Subjective Norm* refers to the overall sum of what others think about a certain behavior. According to the TPB, it is in turn determined by two factors: *Normative Beliefs* and *Motivation to Comply*. *Normative Beliefs* are concerned with the likelihood that important referent individuals or entities approve or disapprove of performing a given behavior. The other factor, *Motivation to Comply*, takes into consideration to what extent a person is motivated to comply with those referent individuals or entities (Ajzen 1991). In other words, an

example of *Normative Beliefs* might be, “What do I believe person x or y thinks about my donating my organs?” An example of *Motivation to Comply* might be, “How much do I care about what person x or y thinks?”

With respect to decision-making based on an Islamic ethico-legal framework, the category of *Subjective Norm* appears to be a significant one for developing health behavior change programs through religious communities. In the *Subjective Norm* domain, a person with high religiosity may consider the most important referent other to be God. An example of *Normative Belief* that a potential Muslim donor may ask himself about would be, “How do I believe God views my donating my organs?” In the *Motivation to Comply* domain, a potential Muslim donor may ask himself, “How important is it to me that I act according to God’s approval or disapproval of my donating my organs?”

Islamic religious scriptures seem to support the paradigm above. For example, the Quran says:

If your fathers, your sons, your brothers, your wives, your tribe, the wealth you have gained, the commerce you fear may slacken, and the homes you love are dearer to you than Allah and His Messenger and the struggle in His cause, then wait until Allah brings about His command. Allah does not guide the corrupt. (Quran 9:24, Murad et al. 2000)

In verses such as this, the Quran exhorts the faithful that their behavior must conform to God’s desires (and, by extension, the teachings of Prophet Muḥammad due to his role as the explainer of Islam’s moral code). They must obey God’s decree in all matters. In terms of the TPB, this means that the Quran is establishing that God’s views regarding the actions a person chooses to perform have a place within the domain of *Subjective Norm*. The verse further states that if one’s familial, social, or economical motivations regarding a certain action clash with God’s will, one should comply with God’s decree at the expense of those other motivations. In other words, if God has decreed that faithful Muslims must perform a certain action, they must perform that action even if their “fathers, sons, brethren, and wives” say otherwise. Through the lens of the TPB, this means that for a Muslim, God’s decree on any matter should be the principal component in the *Normative Beliefs* domain, and the corresponding *Motivation to Comply* should be very high as well.

All this begs the question of how a Muslim is to know what exactly is God’s will on a certain matter. The answer lies in a study of the *Shari‘ah*. The *Oxford Dictionary of Islam* defines *Shari‘ah* as “God’s eternal and immutable will for humanity, as expressed in the Quran and Muḥammad’s example (*Sunnah*), considered binding for all believers; ideal Islamic law.” A closely related term, *Fiqh*, is “the human attempt to understand divine law (*Shari‘ah*). Whereas *Shari‘ah* is immutable and infallible, *Fiqh* is fallible and changeable. *Fiqh* is distinguished from *Uṣūl al-Fiqh*, the methods of

legal interpretation and analysis. *Fiqh* is the product of application of *Uṣūl al-Fiqh*, the total product of human efforts at understanding the divine will.” Therefore, a Muslim may come to know God’s will regarding an ethical matter by researching what the *Shari‘ah* decrees on the matter, as expressed through *Fiqh*. The Islamic ethico-legal tradition encompasses all these concepts. We can, therefore, restate the abovementioned paradigm in the following manner: for an ideal Muslim, the *Shari‘ah*’s stance on any matter should be the predominant component in the *Normative Beliefs* domain, and its corresponding *Motivation to Comply* should be very high as well.

This paradigm is also consistent with the Hadith literature. For example, it is recorded the Prophet Muḥammad is reported to have said, “None of you truly believes until his desires become subservient to that [message] which I have brought” (Nawawi 2003). This tradition equates a Muslim’s level of religiosity with the extent to which he or she willingly conforms to the message of God, or in other words, the *Shari‘ah*. Hence, within the framework of the TPB and *Subjective Norms*, the term “religiosity” can be thought of as interplay between *Normative Beliefs* and *Motivation to Comply*, with the referent entity being God. A “religious” Muslim is one who, in every matter, takes into consideration only God’s command as expressed in the *Shari‘ah* regarding that matter, to the exclusion of all other referent others, when it comes to *Normative Beliefs*, and has a high corresponding *Motivation to Comply*.

THE ‘*ILMĪ* AND *IṢLĀHĪ* IMPERATIVES

When discussing religion in the context of health behavior interventions, understanding the concept of religiosity is essential because the goal of religious leadership in any faith tradition is to increase the religiosity of their followers. Based on the understanding of religiosity through the lens of the TPB as described above, religious leaders tend to work within the area of *Subjective Norm*, at the interface between *Normative Beliefs* and *Motivation to Comply*. In the Islamic tradition, these correlate to two broad imperatives that the ‘*Ulamā*’, Islamic religious leaders, concern themselves with: the ‘*ilmī* imperative, and the *iṣlāhī* imperative.

The Arabic word ‘*ilmī* literally means “scholarly” or “academic.” The ‘*ilmī* imperative is concerned with religious academics. It involves the study, research, and application of *Fiqh*.³ The *fuqahā* can be more precisely understood as Islamic scholars who apply their jurisprudential knowledge, particularly their knowledge of *Uṣūl al-Fiqh*, to the scriptures in an attempt to determine whether a particular action lies within the Islamic ethico-legal tradition on the scale of permissible, impermissible, or somewhere in between. In doing so, the fundamental question they are trying to answer is: What is the moral injunction attached to that particular action in a

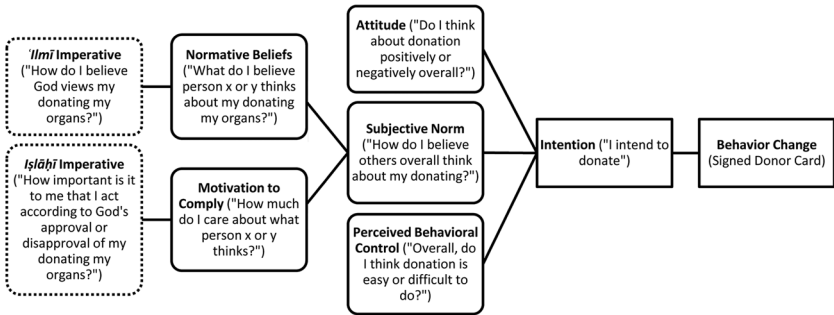


Figure 1. A diagram of the theory of planned behavior in the case of organ donation, with a focus on *subjective norms*, and a demonstration of how the *ʿilmī* and *islāhī* imperatives correspond.

certain circumstance? The *fuqahāʿ*, whether they act collectively as in an ethico-legal council, or separately as independent *mufṭīs*, are representatives of this *ʿilmī* imperative. *Fatāwā* are the most common form in which they express the conclusions they arrive at in their attempt to answer that fundamental question.⁴ In terms of the TPB, the *fatwā* can be thought of as the juriconsult’s attempt to discern an approximation of God’s will, through the channel of *Fiqh*. Therefore, it corresponds most directly to the *Normative Beliefs* component of *Subjective Norms*.

The second imperative, the *islāhī*, literally means “reformatory” in Arabic. Its goal is to spiritually reform and rectify the Muslim masses.⁵ It is concerned with providing the Muslim public with on-the-ground religious guidance by exhorting them to the worship of God and giving them religious and moral counsel. An *islāhī* message might focus on topics such as the importance of developing good character, the virtues of prayer, and the reward one will receive for leading a pious life. Examples of representatives of the *islāhī* imperative are broad and include chaplains, preachers, local imāms, Sufi *shaykhs*, and counselors. Within the TPB-based framework, the *islāhī* imperative most directly corresponds to the *Motivation to Comply* component of *Subjective Norms*. This is because they focus on trying to exhort and persuade Muslims to take heed to God’s will and be as compliant to His decrees as possible.

A harmonious interplay between the *ʿilmī* and *islāhī* imperatives of Islamic religious leadership is important in religiously motivated behavior change. Without the *ʿilmī* imperative, one would not be aware of what the *Shariʿah* dictates regarding matters of concern, thereby crippling the *Normative Beliefs* domain, and without the *islāhī* imperative, one would not be sufficiently motivated to comply with those beliefs even if they were well known.

ṬAṆṬĀWĪ VERSUS SHA‘RĀWĪ

To provide a practical example of the above-explained theoretical framework at play, we will examine the case of two opposing viewpoints on organ donation by two different Egyptian Muslim scholars.

Muḥammad Sayyid al-Ṭaṇṭāwī (1928–2010) was the Grand *Muftī* of Egypt, and later went on to become the Grand *Shaykh* of the University of al-Azhar, the same institution where he had been trained and had earned his doctorate degree in Quranic Exegesis. In 1989, Ṭaṇṭāwī penned a *fatwā* that gave wide latitude to the practice of organ transplantation, determining it to be Islamically permissible to transplant the organs of one person into another person (Ṭaṇṭāwī 1987). Ṭaṇṭāwī’s *fatwā* was a scholarly treatise utilized the method and science of Islamic ethico-legal reasoning through *Uṣūl al-Fiqh*. His opinion of permissibility rode on the back of a long line of Egyptian Grand *Muftīs* who had also permitted donation and transplantation.

Ṭaṇṭāwī was speaking from an *‘ilmī* channel because he expressed his opinion in the form of a formal *fatwā* written in classical Arabic and distributed within scholarly, policy and public circles. In terms of the TPB, Ṭaṇṭāwī’s *fatwā* is essentially an expression of his opinion that God approves of, and may even encourage, donation. Therefore, it correlates with *Normative Beliefs*.

The second scholar, Muḥammad Mitwalli al-Sha‘rāwī (1911–1998), was a prominent late twentieth century cleric and preacher. Like Ṭaṇṭāwī, he also graduated from the University of al-Azhar, and went on to teach *Shari‘ah* and *Uṣūl al-Dīn* in Egypt, Algeria, and Saudi Arabia. He is most renowned for his regular appearances on religious television in the 1970s and 1980s. Unlike Ṭaṇṭāwī, Sha‘rāwī preached that organ transplantation was impermissible in all its forms, citing the idea that humans are simply stewards of the God-given endowment of a body. Sha‘rāwī addressed organ donation spontaneously during his television show by rhetorically asking, “How can you give a kidney that you yourself do not own?” Sha‘rāwī’s opinion could not be called a *fatwā* in the normal sense, which tends to be formal and employs legal reasoning. Nevertheless, he did express an opinion of impermissibility. By Sha‘rāwī claiming that organ donation was impermissible, he essentially said that God willed for the Muslims not to donate. In that sense, Sha‘rāwī’s claim could also fall into the category of *Normative Beliefs*.

On top of merely expressing his opinion on donation, however, Sha‘rāwī also did something Ṭaṇṭāwī did not: Sha‘rāwī expressed his opinion through *islāhī* channels. The forum in which he expressed his opinion was that of a television show broadcast every day to Muslim viewers. He spoke in the vernacular of the Egyptian street as opposed to the formal classical Arabic commonly employed in *fatwā*. Clearly, his opinion manifested

an *islāhī* imperative through directly addressing people on the ground on their terms. In the show, Sha‘rāwi was expressing an opinion not as a legal verdict but as a springboard for the spiritual lesson that all Muslims are utterly dependent on God and that they must therefore live their lives in His obedience. By doing so, his message also fell into the category of *Motivation to Comply*.

While Ṭantāwi had only targeted one component of *Subjective Norm*, Sha‘rāwi had targeted both. Which religious leader, then, was more effective in promoting this health behavior change? Clearly, Sha‘rāwi’s opinion resonated with the Egyptian people much more powerfully than Ṭantāwi’s. For instance, medical anthropologist Sherine Hamdy writes: “[A]mong most of the dialysis patients I interviewed, all the Islamic scholars, and even many transplant physicians, it was Sha‘rāwi’s opinion that was most often cited and held the deepest resonance among patients in need of kidney transplants” (Hamdy 2008). In light of the TPB, this is no surprise because Ṭantāwi’s opinion only correlated to *Normative Beliefs*, but Sha‘rāwi’s opinion correlated to both *Normative Beliefs* and *Motivation to Comply*. It was Sha‘rāwi’s inclusion of the *islāhī* imperative, tying organ donation to the larger issue of reliance on God, and *islāhī* channels, the television show, that allowed his opinion to reach and then resonate with the Egyptian laity.

The *‘ilmī/islāhī* and *Normative Beliefs/Motivation to Comply* dichotomies have profound implications for health behavior change interventions that target Muslims.⁶ By extrapolating from the case of Sha‘rāwi, we learn that the most successful interventions that target religion-related factors must incorporate both *Normative Beliefs* and *Motivation to Comply*, or in other words, they must work through the *‘ilmī* imperative as well as the *islāhī* imperative.

INTERVENTIONS REVISITED

As noted when previously discussing health behavior interventions targeting Muslims, bioethics researchers and health behavior interventionists have most often partnered with the *fuqahā’*, which is to say the *‘ilmī* imperative, to overcome Muslim reticence toward organ donation. In the process, they have often overlooked the crucial role of the *islāhī* imperative in behavior change. Interventions that reach out to local *imāms*, preachers, teachers, and other representatives of that imperative are few and far between.⁷

Representatives of the *islāhī* imperative play a crucial role in delivering religious messages for several reasons. One reason that *islāhī* representatives must be involved is the technical nature of most *fatāwā*. The *fatwā* has traditionally been a tool of the *‘ilmī* imperative because the qualifications one must have in order to issue a recognized *fatwā* are distinctly scholarly.

For instance, a *muftī* that passes *fatāwā* must have a comprehensive understanding of Islamic ethics, law, theology, and other relevant disciplines. The vocabulary of these disciplines is often quite specialized. If the *fatwā* is short and the question is simple, the *muftī* and the lay Muslim might interact with one another in person. If the matter is more complicated, however, and the *muftī* must employ more sophisticated legal reasoning, the laity often depends upon a trusted representative of the *islāhī* imperative, such as the local *imām* or religious mentor, to interpret these *fatāwā*.

A second reason is that the *islāhī* imperative is more than merely a passive echo of the *ilmī* imperative, and *islāhī*-focused *ulamā* frequently use personal discretion when passing religious messages from the *fuqahā* to the laity. For example, an *islāhī*-focused *imām* may advise his congregation against donation because he feels that the view of impermissibility is more ethico-legally sound, for even though the majority of *fuqahā* have ruled that organ donation is permissible, other *fuqahā* still hold the view of impermissibility. Alternatively, the *imām* may not be aware of *fatāwā* that allow donation and will therefore discourage it. This is seen in another Saudi study in which researchers list the “Local Imām Factor” as one of the barriers to donation and transplantation among Saudi Muslims. They observed that a health care professional may inform the relative of a potential donor of an official *fatāwā* that permit and even encourage donation. When the relative seeks the opinion of his or her local *imām*, however, the *imām* discourages donation in spite of the *fatwā* (al-Khader et al. 2003).

This is also illustrated in a British study that said local clerics are “very influential” to lay Muslims considering donation (Alkhwari et al. 2005). The study found that ten subjects actually admitted to canceling their donor cards on the advice of their local *imāms*. Upon questioning the *imāms* that these ten subjects had consulted, the authors reported that the *imāms* were hesitant to discuss the matter of donation and transplantation, stressing the disagreement between the *fuqahā* on the issue. They also had little knowledge of the organ donation program in the United Kingdom. If interventions attempting to increase British Muslim donor rates had reached out to these *imāms*, it is likely that they would have been better-informed about organ transplant processes, and may have subsequently encouraged donation to their congregation.

A third reason for the importance of the *islāhī* imperative is that even if the laity is quite capable of reading and understanding the *fatwā* for themselves without the help of the likes of an *imām*, they may not be sufficiently motivated to act upon the *fatwā* without persuasion and exhortation from representatives of the *islāhī* imperative. To put it another way, their *Motivation to Comply* was not sufficiently high enough to lead to an intention to donate. An example to illustrate this is a study that surveyed 22 Saudi Muslim physicians. The study notes:

Ninety percent of the intensivists knew about the Islamic view on organ donation [i.e. the view of permissibility expressed by the Saudi Senior ‘Ulamā’ Council]. Seventy-two percent would agree on donation if one of their relatives became brain dead, 12 would not agree, and one could not decide; however, only 13% carry donation cards. (al-Sebayel and Khalaf 2004)

Here we see that the subjects were quite aware that Saudi *fuqahā’* had ruled donation to be permissible. The subjects had even agreed to the theoretical concept of donation since most of them were willing to consent to the harvesting of a brain-dead relative’s organs. They had not, however, been motivated to take action and sign donor cards themselves. One of the reasons why this may be is that the *fatwā* did not come to them through *islāhī* channels. If an *imām* had first preached to the study participants that they *should* donate because they would, for instance, receive reward in the afterlife for their charity, then perhaps the percentage of subjects carrying donor cards would have been higher.

This is also illustrated by the previously mentioned intervention in Birmingham that led to the *fatwā* in 1995 by the UK Muslim Council which was considered unsuccessful. One possible explanation for its lack of success may be that it seems not to have been well disseminated through *islāhī* channels. Publicity of the *fatwā* was limited to a news item on the morning edition of Radio 4; television coverage on the local evening news in the area where the *fatwā* had been initiated; and limited coverage in two Asian newspapers. It was also quoted in a brochure by UK Transplant (Ghaly 2012a). The dissemination of this *fatwā* was diffuse and limited. Randhawa states that “the publicity campaign was not utilizing effective channels of communication for informing the Muslim population” (1998). While Sha’rāwī’s view also employed television for dissemination, his program was by contrast broadcast all throughout the Middle East, and he already had a following at the time he expressed his view on donation (Hamdy 2008).

Even if it had been well disseminated, however, the main shortcoming of this initiative in light of the TPB and the presented theoretical framework was that it targeted the *‘ilmī* imperative without giving due importance to the *islāhī* imperative. It can be likened to Ṭanṭāwī’s *fatwā* in that it satisfied the domain of *Normative Beliefs*, but *Motivation to Comply* was given less attention. The initiative might have been more successful if after the *fatwā* had been passed, for instance, the Birmingham Organ Co-ordination Team had worked with local mosques to arrange seminars to educate local *imāms* about the *fatwā* and to encourage Friday preachers to encourage donation among their congregation in a rewards-based *islāhī* context such as the rewards the Quran promises for saving a life or showing altruism. For organ donation to become more common among Muslims, there must be preachers understanding the Islamic value of organ donation and being

motivated to exhort the community to consider organ donation as part and parcel of being a good Muslim.

The case of The Netherlands is an example of attempts to increase Muslim donor rates that incorporated, at least partially, actors of both the *islāhī* and the *ilmī* imperative. The Dutch *Milli Görüs*, the Netherlands-based branch of a Turkish social-religious organization, collaborated with The Netherlands Institute of Health Promotion and Disease Prevention (NIGZ) to promote public awareness of organ donation among Muslims in the Netherlands through a project called *Geven en Nemen* (Give and Take) which was started in October 2005. The project aimed to have the issue of organ donation raised during the Friday sermon in all mosques affiliated with *Milli Görüs*, resulting in the dissemination of an *islāhī* message promoting organ donation to an estimated 30,000 Muslims in the congregations. The *imāms* and eminent board members of *Milli Görüs* suggested that they would express their support of donation and encourage the congregation to donate (Ghaly 2012b). This intervention was very different from most previous interventions due to the involvement of *imāms* and *islāhī*-focused Islamic religious leaders as opposed to only *fuqahā*.

Another noteworthy initiative in The Netherlands related to increasing Muslim donor rates was a conference on Islam and organ donation held by a Dutch organization called the Contact Group for the Relations between Muslim Organizations and Government (CMO). While this was not a health behavior change intervention per say, it is relevant in that it engaged the issue of organ donation among Muslims in The Netherlands. At the conference, a twenty-page *fatwā* that endorsed organ donation in the Islamic ethico-legal tradition was presented (Ghaly 2012b). The *fatwā* analyzed the issue from many different angles and addressed legal questions that previous *fatāwā* had left unanswered, such as the interreligious dimensions of organ donation, namely donating organs to or receiving organs from non-Muslims. The presentation of the *fatwā* was a manifestation of the *ilmī* imperative, but the conference was also a demonstration of the *islāhī* imperative, at least to a small extent, because at least a hundred *imāms* attended the conference, and the NIGZ developed brochures quoting the declaration of this conference, both in Arabic and Turkish, and available online and in printed form.

Although empirical studies that assess the increase in donor rates resulting from the interventions in The Netherlands are still wanting, there are some positive signs. One small study noted a slight increase in the number of registered donors in 2007, compared with 2005, among Dutch people with Muslim-country origins (Moroccan and Surinamese) (Ghaly 2012b). Furthermore, some *imāms* suggested they would now promote organ donation after attending the CMO conference. As one of them said, "We follow the advice of our scholars and we will allow organ donation,"

upon which the audience, which included many *imāms*, applauded (Ghaly 2012b).

On the other hand, however, other studies suggest that the number of registered Muslim donors has remained unchanged, largely due to their uncertainty about the stance of their religion toward donation (Ghaly 2012b). Hence further work needs to clarify the effectiveness of efforts to increase Muslim donor rates such as the above-mentioned ones by the *Milli Görüş* and the CMO. Although encouraging, a critical failing of these efforts, in the light of TPB, is that the theory (as well as all other behavioral change models) require robust interventions that target specific barrier beliefs, for example, organ donation desecrates the body, through tailored messaging, for example, organ donation processes maintain respect for the donor body and procuring organs from the dead is Islamically permissible. The *Milli Görüş* intervention, as well as the CMO conference, appears to have placed more emphasis on the widespread dissemination of *fātāwā* of permissibility rather than focused *islāhī* messaging that attempts to dispel myths and change barrier beliefs. Further, while the *imāms* at the conference may have resolved to support organ donation we do not know to what extent they organized classes, lectures, workshops, and other programs at their mosques that actively promoted organ donation through targeted and tailored messaging. Nevertheless, the case of The Netherlands represents an encouraging first step.

CONCLUSION

This article has two objectives. The first one, the broader of the two, is to propose a new model for thinking about Islamic religious leadership. Too often among the medical community, the '*ulamā*' are thought of as a homogenous, static, and monolithic body. It is hoped that the '*ilmī/islāhī*' dichotomy will offer a touch of nuance to this image and lead to a new and more accurate understanding of the '*ulamā*'. A clearer picture of the relationships between lay Muslims and the multiple levels of Islamic religious leadership will allow for more conducive collaborations between medical researchers and the Muslim community.

The second objective is to call attention within the medical community to the importance of reaching out to the representatives of the *islāhī* imperative among Islamic religious leadership. While much research has been conducted on what the Islamic ethico-legal tradition says about various issues in medical ethics, few studies have examined how Islamic bioethics plays out on the ground. Speaking about the scant collaboration with local *imāms*, a study notes:

The community role of . . . [a] mosque-based *imam* is analogous to the role of Christian priests or ministers and Jewish rabbis. However, while the medical literature is replete with studies describing partnerships with

rabbis and priests to improve Jewish and Christian health, respectively, and chaplaincy programs have effectively incorporated these faith leaders within hospital systems, few *imams* have been included in such initiatives, and little is known about their multiple roles in American Muslim health. (Padela et al. 2010b)

And yet, this incorporation is critical because without these *imāms* to couple the *islāhī* imperative with a *fatwā*, the *fatāwā* are less likely to be effective agents of health behavior change. To begin this initiative of reaching out to representatives of the *islāhī* imperative, we suggest that there is a need to conduct studies on the opinions of local *imāms* and preachers in order to clarify what they feel are barriers to their involvement in health promotion, their concerns over promoting health practices donation in sermons, and their reading of community health challenges. In the aforementioned study, for example, some *imāms* were concerned about health workers “co-opting” religion for health goals and “expressed discomfort with being asked to convince patients to pursue physician recommendations through religion-based arguments” (Padela et al. 2010b).

For future health behavior change interventions, we propose a multifaceted model that is informed by the proposed theoretical framework derived from the TPB. Interventions should focus on changing not behavior or intention but rather the more upstream determinants of behavior change, with a particular emphasis on *Subjective Norm*. The *Normative Beliefs* component should be addressed by encouraging *fuqahā*’ and ethico-legal councils to research the understudied issues in health and medicine, such as organ donation, and tackle the controversial points from the lens of Islamic Law. At the same time, interventionists must give equal attention to the *Motivation to Comply* component by reaching out to representatives of the *islāhī* imperative. They should be informed of what Muslim jurists from a wide variety of intellectual and ethnic backgrounds have ruled regarding the proposed health behavior intervention. They should then be encouraged to frame the intervention to their congregation in an *islāhī* context, perhaps by mentioning it in the Friday sermon, or by holding classes at the mosque on the topic.

The ideas presented are not without limitations or qualifiers. One example of issues that require further consideration is that some Muslims may feel uneasy with initiatives that use *islāhī* messages to promote health behavior change, possibly perceiving these initiatives as employing Islam as a mere tool to achieve worldly objectives. In the previously mentioned study, for instance, one respondent states:

I think using religious venues and sharing common values is okay. So going to the masjid [mosques] and encouraging women to get their mammograms and . . . men to get their prostate exams, for people to get colonoscopies—that’s totally cool . . . when you go to the next step and you say that

Allah wants you to get a colonoscopy . . . I get nervous . . . that's not my understanding of my religion. (Padela et al. 2010b)

Therefore, as the authors write, “there seems to be an ethical line between coercing Muslims to seek healthcare using religiously laden messages and general health promotion activities at the mosque” (Padela et al. 2010b).

Another challenge for medical researchers in practically approaching the *islāhī* imperative is that it is much more diverse than the *‘ilmī* imperative. The *islāhī* imperative includes a broad range of religious leaders who share the common role of middlemen in educating the Muslim masses and guiding them in matters of religion. Some are *imāms* of mosques, but others include televangelists, community service workers, chaplains, and counselors. The question for health behavior interventionists when attempting to reach out to them is where to start? As a practical starting point in the United States, they should work to develop linkages with umbrella organizations such as the Islamic Society of North America or the North American Imāms Federation, where *imāms* and community leaders may come together to discuss health challenges and bioethical issues facing the Muslim community and work toward implementing change in health behaviors.

Another point that deserves mentioning is that in the presented theoretical framework, we have only discussed religious factors that determine the intention to donate. We mentioned previously that in the religious context, the *Motivation to Comply* domain would theoretically encourage Muslims to act in accordance to God's decree, as conveyed through the *Sharī‘ah*, to the exclusion of all other referent others such as family, society, or government. While a very religious Muslim may consider God and nothing else in his or her decision to donate organs, in reality nonreligious factors affecting the intent to donate will invariably apply to varying extents for the majority of Muslims. Religion is but one factor in motivating health behavior, and it may or may not be the most significant from person to person. Therefore, the proposed multifaceted approach to health behavior intervention must also address nonreligious factors such as acculturation, adequate dissemination of health information, and the overcoming of any language barriers.

The issue of translational application is also noteworthy. The dynamics of the way the *‘ilmī* and *islāhī* imperatives manifest themselves differ from region to region, most obviously between countries of Muslim majority versus minority. In the case of the *‘ilmī* imperative, collaboration may be relatively straightforward in a country like Egypt which has a state-sponsored body responsible for *fatwā* (*Dār al-Iftā’ al-Miṣrīyyah*), as well as a well-recognized system for dissemination and research of religious knowledge. In Britain or the United States, on the other hand, the situation is not so clear-cut. Without authoritative institutions for *fatwā*

application, every Muslim in a nonmajority context must decide for him- or herself which *fatwā* to abide by or which scholar to follow.⁸ Similarly in the case of the *islāhī* imperative, the local *imām* serves a much more dynamic role within the community in countries of Muslim minority. He at once serves the role of a counselor, teacher, *muftī*, and preacher. Therefore, his *islāhī* messages can be transmitted through multiple channels of influence. In countries of Muslim majority, on the other hand, people obtain *islāhī* messages from different avenues. The health behavior interventionist must take all these nuances into consideration for intervention to be successful.

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NOTES

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1. *Fuqahā'* (sing. *Faqīh*): Muslim jurists/consultants and experts in Islamic law.
2. A *fatwā* (pl. *fatāwā*) is a nonbinding ethico-legal opinion issued by a Muslim jurist/consultant who is trained in issuing these opinions, known as a *muftī*. Typically, a lay Muslim will ask the *muftī* whether a particular action is permissible or impermissible according to the Islamic ethico-legal tradition, and the *muftī* will draw on evidence from the sacred scriptures and precedent cases to provide an answer in the form of a *fatwā*. If the question is a simple one that requires little research, the *fatwā* that the *muftī* issues might simply be a verbal reply or a written response as short as a few sentences. In the case of more controversial issues, however, *fatāwā* frequently take the form research-based opinion papers that other scholars may critique. Studies that attempt to explore Islam's stance regarding the ethics of organ transplant treatment frequently involve analyzing such *fatāwā*. For instance, Vardit Rispler-Chaim's study to determine the Islamic stances on bioethical issues is based almost exclusively on her examinations of Egyptian *fatāwā* in the twentieth century (Rispler-Chaim 1993).
3. Other subdisciplines of Islamic academics such as *Tafsīr* (Quranic exegesis), *ʿIlm al-Ḥadīth* (Hadith criticism), and *ʿIlm al-Lughah* (Arabic linguistics) are ancillary sciences because although they can be studied for their own sake, the primary objective in their study is their application in *Fiqh*. The notable exception is *Aqīdah*, or Theology. While *Fiqh* is the study of ascertaining God's will as it relates to human practices, *Aqīdah* does the same with relation to human beliefs about the divine. As there is much overlap between these disciplines, it is at times helpful to think of *Fiqh* in a universal sense as a discipline that studies how to conform to God's will in a holistic context. This understanding, favored by *ʿulamā'* of the earlier periods, is exemplified by *Imām* Abū Ḥanīfah's well-known holistic definition of *Fiqh* as “an individual's recognition of his rights and responsibilities” (*maʿrifat al-nafsi mā lahā wa mā ʿalayhā*).

4. *Qarārāt*, or resolutions, are another form that might be issued on behalf of an ethico-legal council.

5. Note that the kind of reform used here does not refer to religious, social, or political reform. The *islāhī* imperative is not concerned with reforming Islam. Rather, it refers to personal spiritual reform and growth.

6. For ease of explanation, the *'ilmī* and *islāhī* imperatives are presented in this article as highly distinct from one another. In reality, the distinction is not always so clear-cut. While the educational qualifications for *'ulamā'* operating under the guise of each imperative are different, many scholars have the academic skill-set to operate in both. For example, Ṭanṭāwī and Sha'rawī maintained the same academic qualifications more or less but operated predominately in different circles. In this way, some *'ulamā'* may refrain from issuing *fatāwā* and remain preachers in the mosque, while others dedicate themselves to research and writing and rarely deliver sermons or speak to the masses directly. Yet, scholars are not restricted to either the scholarly or *islāhī* channels all the time; when Ṭanṭāwī would deliver the sermon on Friday Prayer, he would be speaking through an *islāhī* channel, and when Sha'rawī would teach Islamic Law at the university, he would adopt a scholarly channel.

7. Alternatively, interventions may partner with these *imāms* but not in a manner the TPB would suggest. Such is the case of The Netherlands which we discuss below.

8. Here, again, the issue of nonreligious factors becomes relevant because while some Muslims might research and survey the various *'ilmī* opinions and choose to follow the one they feel makes the strongest arguments, other Muslims might determine which *fatwā* or *muftī* to follow based on nonreligious factors. For instance, they may simply follow the opinions of *muftīs* from their own country of origin, or the one they find to be the most charismatic.

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