



Supported Decision Making in Healthcare: Integrating the Principles of *Syūrā*, *Hifz al-Nafs*, and Patient Legal Protection

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Abstract

Background: Medical consent may be formally valid while still failing to demonstrate patient understanding, voluntariness, and meaningful participation.

Objective: This conceptual article examines supported decision-making as a model of legal protection for patients through the integration of *syūrā* and *hifz al-nafs*.

Methods: This literature-based conceptual paper uses a narrative-integrative synthesis of primary legal materials and scholarly literature on health law, informed consent, autonomy, supported decision-making, and Islamic bioethics.

Results: The synthesis constructs a five-element model: patient primacy, understandable information, a patient-approved companion or facilitator, protection against domination or substitution of the patient's will, and documentation of the decision-making process. *Syūrā* functions as the deliberative procedure through which patients, families, and healthcare professionals clarify options without displacing the patient's will; *hifz al-nafs* functions as the normative orientation toward life, safety, dignity, welfare, and harm prevention.

Conclusion: The model reconstructs the procedural implementation of informed consent rather than replacing its legal doctrine. It provides a conceptual basis for process-based legal protection, while its practical effects require future empirical and normative validation.

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INTRODUCTION

Contemporary healthcare services operate within increasingly complex relational spaces, as medical decisions can no longer be understood solely as matters of physicians' professional authority, but rather as legal, ethical, and social processes that require meaningful patient participation. In the discourse of bioethics and health law, informed consent is positioned as a primary instrument for protecting patient autonomy through the disclosure of information concerning diagnosis, medical procedures, risks, benefits, alternatives, and the consequences of a healthcare intervention. However, recent developments indicate that formally valid medical consent does not necessarily reflect a genuinely autonomous decision if the patient does not understand the information provided, is unable to process the risks involved, or is situated within particular relational pressures (Lewis, 2023). Criticism of medical consent models that are overly centered on information disclosure has also emerged because many patients, particularly those from vulnerable groups, experience gaps in health literacy, unequal power relations with

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healthcare professionals, and difficulties understanding technical consent documents (Koch, 2024). In the Indonesian context, health law has established consent to medical treatment and patient rights as essential components of legal protection, yet such regulation continues to face challenges when applied to patients with disabilities, language barriers, limited literacy, or clinical conditions that reduce their ability to understand information independently (Masyuri et al., 2024). Therefore, patient decision-making in healthcare must be viewed not merely as a matter of consent administration, but also as a matter of justice, protection of life, and fulfillment of human dignity within the therapeutic relationship. Substantive autonomy can be distinguished from formal validity by four indicators: understandable disclosure, demonstrated comprehension, voluntary expression free from coercion, and a decision traceable to the patient's own values.

The academic and practical gap arising from this issue lies in the inadequacy of a formalistic informed consent approach to ensure that patients truly remain the primary subjects of medical decisions. Literature on medical decision-making shows that the supported decision-making model emerges from the need to ensure that individuals with cognitive or communication barriers, older adults, disabilities, or social vulnerabilities receive the necessary support to make their own decisions without having those decisions replaced by others (Donnell et al., 2023). In clinical practice, support for patient decision-making may be provided through the use of simple language, clear interview structures, visualization of information, priority cards, simplified consent documents, and patient-centered facilitation, particularly in situations where patients experience cognitive impairment, such as dementia (Wied et al., 2021).

This gap becomes increasingly significant because autonomy in healthcare decisions is not determined solely by individual capacity, but is also influenced by education, economic status, family relationships, culture, religion, and access to comprehensible information (Idris et al., 2023). Thus, the urgency of this article lies in the need to construct a conceptual model that bridges patient rights, medical communication, relational support, and legal protection within a more substantive framework. The gaps are threefold: practically, consent forms may not ensure meaningful participation; legally and conceptually, document-centered protection does not adequately specify a support process; and academically, prior scholarship has not sufficiently integrated supported decision-making, *syūrā*, *hifz al-nafs*, and patient legal protection into a single model. Donnell et al. (2023) identify relational power barriers, Wied et al. (2021) describe communication supports, and Padela (2022) notes the operational challenge of *maqāṣid* models; none constructs the present integrated legal-protection model.

Conceptually, this study connects supported decision-making with the principles of *syūrā* and *hifz al-nafs* in Islamic legal philosophy. In modern health law scholarship, supported decision-making is understood as a mechanism that continues to position the patient as the primary decision-maker, while support from family members, companions, healthcare professionals, or facilitators serves to assist the patient in understanding information, clarifying values, weighing alternatives, and expressing their will voluntarily (Appelbaum et al., 2021). This understanding is consistent with the idea that autonomy is not absolutely individualistic, since human decision-making in medical contexts often depends on social, cognitive, emotional, and epistemic support that enables individuals to understand and choose actions aligned with their life values (Allen et al., 2025). From the perspective of Islamic legal philosophy, the principle of *syūrā* may be understood as a deliberative foundation that requires consultation, consideration, and communication without negating the patient's will, while *hifz al-nafs* positions the protection of life as the normative orientation of healthcare decision-making. This framework is relevant to the development of contemporary Islamic bioethics, which seeks to harmonize autonomy, welfare, prevention of harm, professional trustworthiness, and justice in modern medical practice (Rahman et al., 2025). *Syūrā* is selected because it supplies a procedural principle of patient-centered deliberation, whereas *hifz al-nafs* is selected because it supplies a substantive orientation toward the protection of life, safety, dignity, and welfare. Their distinct roles prevent Islamic principles from being invoked merely as general moral claims.

Based on this framework, the article aims to: (1) clarify how supported decision-making strengthens patients' legal position in consent to medical treatment; (2) explain *syūrā* as a

deliberative procedure and *hifz al-nafs* as a normative orientation; and (3) formulate an integrated conceptual model of patient legal protection. This is a literature-based conceptual analysis using narrative-integrative synthesis, rather than empirical testing or a systematic review.

The scientific contribution of this article lies in its effort to reconstruct supported decision-making as a model of patient legal protection grounded in Islamic legal philosophy, rather than merely as a bioethical concept or a clinical communication procedure. *Maqāṣid*-based scholarship in Islamic medical ethics continues to face conceptual challenges, as the application of *maqāṣid* in the clinical domain is often considered insufficiently operational to address concrete dilemmas at the bedside unless it is developed into a clearer method of deliberation (Padela, 2022). This article offers novelty by positioning *syūrā* as a deliberative procedure, *hifz al-nafs* as an orientation toward the protection of the patient's life and dignity, and supported decision-making as a legal-ethical mechanism that ensures support from family members or healthcare professionals does not turn into substitution for the patient's will. Through this construction, the article is expected to contribute to the development of contemporary Islamic health law, particularly by building a model of medical consent that is more substantive, inclusive, participatory, and oriented toward protecting patients as human beings with rights, will, vulnerability, and dignity. Unlike prior models that separately discuss consent doctrine, decision support, or *maqāṣid* ethics, this article specifies the division of functions within one paradigm: supported decision-making is the procedural support mechanism, *syūrā* structures deliberation, and *hifz al-nafs* supplies the normative standard for evaluating whether the process protects the patient.

METHOD

This study employed a literature-based conceptual paper design using narrative-integrative synthesis. This approach was chosen because the study did not seek to test empirical data or conduct a statistical meta-analysis, but rather to develop a conceptual framework of *supported decision making* in healthcare through the integration of *syūrā*, *hifz al-nafs*, and patient legal protection (Jaakkola, 2020; Pichlak et al., 2025). The term "literature" referred to legal materials and scholarly sources used for conceptual analysis; the article did not claim to constitute a systematic review, meta-analysis, or analysis of an empirical dataset.

The materials comprised primary legal sources (statutes, regulations, and official legal documents on patient rights, healthcare services, informed consent, and patient protection) and secondary scholarly sources, including peer-reviewed journal articles, academic books, and research on supported decision making, autonomy, Islamic bioethics, and *maqāṣid*. Sources published within the last five years were prioritized but were not required; foundational or methodologically essential sources published earlier, as well as relevant non-open-access publications, were included where bibliographic access was available. Source credibility was assessed based on identifiable authorship, a verifiable publisher or journal, peer review or recognized academic publication status, and direct conceptual relevance.

The literature was identified through Google Scholar, PubMed, DOAJ, Crossref, indexed repositories, open-access journal portals, and official legal sources using combinations of keywords related to supported decision making, informed consent, patient autonomy, patient legal protection, *maqāṣid al-sharī'ah*, *hifz al-nafs*, *syūrā*, and Indonesian medical consent law. Searches were documented by source, keyword combination, and relevance screening. PRISMA 2020 was not applied because this article did not report the identification, duplicate removal, screening, exclusion, and inclusion counts required for a systematic review.

The inclusion criteria were direct relevance to patient decision making, informed consent, patient legal protection, Islamic bioethics, or *maqāṣid*-based healthcare ethics; complete and traceable bibliographic information; and academic credibility as demonstrated by peer review, publication by a recognized academic publisher, or issuance by an official legal authority. Non-academic writings, unsupported opinion pieces, duplicate records, sources with unclear provenance, and materials unrelated to the conceptual model were excluded.

The units of analysis comprised concepts, principles, legal norms, and scholarly arguments. The analytical process proceeded from the extraction of relevant passages to the

initial coding of limitations in informed consent, decision-support mechanisms, relational autonomy, power relations, Islamic ethical principles, and legal protection. The codes were then consolidated into six thematic categories. Cross-theme comparison generated five recurring model elements: patient primacy, understandable information, a patient-approved companion or facilitator, protection from domination, and documentation. Conceptual validity was maintained by checking each element against the included legal, bioethical, and Islamic-philosophical sources before the final model was formulated.

RESULTS AND DISCUSSION

Results

Literature Mapping and Conceptual Clusters

The literature mapping indicates that publications relevant to supported decision-making in healthcare are distributed across four main clusters: literature on informed consent; literature on shared decision-making and supported decision-making; literature on relational patient autonomy; and literature on *maqāṣid al-sharī'ah* and Islamic bioethics. In the first cluster, studies on informed consent consistently show that medical consent is not merely a legal obligation to provide information, but also a process that requires understanding, competence, voluntariness, and the patient's ability to express a conscious choice. Appelbaum (2021) position supported decision-making as compatible with the doctrine of informed consent because the patient remains the decision-maker, while support is provided to help the patient meet the requirements of understanding, reasoning, and voluntary choice (Appelbaum et al., 2021). In a more legal-institutional context, studies on shared decision-making and medical consent legislation show that shared decision-making has developed beyond traditional informed consent by emphasizing mutuality, participant roles, the substance of shared information, and potential legal responsibility when the process is inadequate (Yeoran & Hyuna, 2024). In Indonesian literature, medical consent regulation is understood as part of the health law framework, although it still requires stronger inclusive communication for patients with disabilities, language barriers, or limited health literacy (Masyuri et al., 2024). These are findings reported by prior studies. The present study's synthesis begins by comparing these clusters against the problem of legal protection and generating the thematic categories described below.

The synthesis of supported decision-making literature shows that this concept is most frequently used to explain support for patients with cognitive barriers, intellectual disabilities, advanced age, dementia, communication difficulties, or vulnerable social positions within clinical relationships. In studies on patients with dementia, strengthened consent procedures through standardized interview structures, simple language, supportive room design, keyword lists, priority cards, information visualization, simplified consent forms, and patient-centered facilitation have been identified as supportive tools in medical decision-making processes (Wied et al., 2021). In clinical research literature, supported decision-making is mapped as a model that can improve decision-making capacity and the authenticity of choices among individuals with cognitive or intellectual impairments, while remaining distinct from substitute decision-making by guardians or legal representatives (Wendler & Kim, 2022). In acute care for older persons and persons with disabilities, the reviewed literature shows that power relations, professional hierarchy, physician dominance, risk-averse organizational culture, and competence-based assessments of cognitive capacity are recurring themes in supported decision-making processes (Donnell et al., 2023).

The mapping of patient autonomy literature shows that relational autonomy has become one of the dominant theoretical approaches for explaining patient involvement in medical decisions. A meta-synthesis on relational autonomy identifies four main themes influencing medical decision-making: supportive relationships that facilitate autonomy, the need for comprehensive information from various sources, family pressure that may hinder patient autonomy, and the dominance of healthcare professionals' voices that may restrict the expression of patient will (Le et al., 2023). A systematic review of patient autonomy in Global South countries further shows that cultural, social, religious, familial, and intersectional factors influence how patients understand and exercise autonomy in healthcare decisions (Akhtar et al., 2024). In

palliative care, an integrative review found that patient participation in shared decision-making occurs not only in decisions about medical interventions, but also in daily care, end-of-life decisions, and decisions involving families and interdisciplinary teams (Kuosmanen et al., 2021).

The literature search also shows that previous studies have used diverse methodological approaches, including conceptual studies, narrative reviews, integrative reviews, systematic reviews, meta-syntheses, qualitative studies, and normative legal research. In shared decision-making literature, narrative reviews are used to expand the practice of shared decision-making by considering social, cultural, environmental, and nonrational factors that influence patient decisions in real clinical settings (Thomas et al., 2021). In the context of patient participation in clinical research, literature-based studies are used to map how shared decision-making can improve patient involvement, reduce psychological barriers, and adapt research processes to patient preferences (Dennstädt et al., 2024). In *maqāṣid* and Islamic bioethics literature, conceptual approaches are used to map the relationship between *sharī'ah* norms, the protection of life, welfare, family, community, and global bioethical debates (Muhsin et al., 2025).

Thematic Categories and the Initial Construction of Supported Decision-Making

The main thematic categories emerging from the reviewed literature can be grouped into six themes. The first is the limitation of formal informed consent, marked by problems of patient understanding, information asymmetry, voluntariness, and the risk of reducing consent to an administrative document. The second is support for patient decision-making, including communication tools, simplified information, accompaniment, facilitation, and clarification of patient values. The third is power relations in healthcare, involving the positions of physicians, families, healthcare organizations, and the legal system in shaping patient participation. The fourth is the sociocultural and religious context, which shows that medical decisions do not always occur within an individualistic framework, but often involve family, community norms, beliefs, and social authority. The fifth is patient legal protection, which includes the right to information, the right to consent to or refuse treatment, the right to participate in decisions, and the need for more substantive documentation of the consent process. The sixth is *maqāṣid al-sharī'ah* in healthcare, particularly *ḥifẓ al-nafs*, *maṣlaḥah*, prevention of harm, and moral responsibility in medical practice. In Islamic bioethics, a *maqāṣid*-based construction includes the protection of religion, life, intellect, lineage, and property, while linking these objectives to welfare, the prevention of harm, trustworthiness, and justice in medical practice (Rahman et al., 2025). An integrative understanding of *ʿaqīdah*, *sharī'ah*, and *akhlāq* is also important because Islamic teachings do not separate belief, norms, and morality in regulating human life; these three dimensions form interrelated foundations for shaping individual conduct and social responsibility in protecting life (Nurhasanah, 2018).

In literature that specifically connects Islamic bioethics with clinical decisions, *ḥifẓ al-nafs* appears as a normative category related to the protection of life, patient safety, and the prevention of harm. In end-of-life contexts, *maqāṣid al-sharī'ah* is used to assess the obligation to disclose diagnoses and prognoses to competent patients, particularly when family dominance prevents patients from receiving information about their own health conditions (Alfahmi, 2022). Other studies on *maqāṣid*-based models for Islamic medical ethics show several forms of development, including field-based redefinition, conceptual expansion, and text-based postulates in addressing clinical dilemmas (Padela, 2022). In this article, *syūrā* is categorized as a deliberative principle because it relates to communication, consideration, consultation, and decision-making processes involving patients, families, healthcare professionals, and companions; meanwhile, *ḥifẓ al-nafs* is categorized as a normative orientation because it concerns the protection of life, safety, dignity, and patient welfare.

The synthesis of the literature produces an initial construction in which supported decision-making in healthcare consists of five recurring elements: the patient as the subject of decision-making, understandable information support, the presence of a companion or facilitator, protection from coercion, domination, or substitution of will, and documentation of the decision-making process. In the mapping of health law and bioethics literature, the element of “the patient as the subject of decision-making” relates to the patient’s right to information and choice;

“information support” relates to the use of simple language, visualization, risk explanation, and clarification of alternatives; “companion or facilitator” refers to family members, healthcare professionals, interpreters, or other parties who assist the patient in understanding choices; “protection from domination” concerns the prevention of family or professional pressure; and “documentation of the decision-making process” relates to legal evidence that the patient’s decision was formed through a conscious, voluntary, and traceable process. These five elements connect supported decision-making with *syūrā*, *ḥifẓ al-nafs*, and patient legal protection. Conceptual model (inline): Patient primacy → understandable information → patient-approved facilitation and *syūrā*-based deliberation → protection from domination/substitution → verification and documentation of patient will, all evaluated against *ḥifẓ al-nafs* as the orientation toward the protection of life, safety, dignity, welfare, and the prevention of harm. This model is a synthesis of the reviewed literature, not an empirically tested intervention.

Discussions

Supported Decision Making as a Reconstruction of Informed Consent

The main finding of this article shows that supported decision-making can be positioned as a conceptual bridge between informed consent, patient autonomy, relational support, and legal protection in healthcare. The literature indicates that the central problem of medical consent is not merely whether a consent form exists, but whether the patient truly understands the information, is able to weigh the available choices, is free from pressure, and remains the primary decision maker in clinical decisions. In relation to the research objective, this finding answers the first research question by showing that supported decision-making strengthens the patient’s position as a legal subject because the support provided is not intended to replace the patient’s will, but to enhance the patient’s capacity to understand, assess, and express medical choices. This concept is consistent with the idea of scaffolding informed consent, namely, that autonomy in medical consent is not purely individual but often requires epistemic, social, and communicative support so that the patient’s decision can truly be regarded as autonomous (Wilkinson & Levy, 2024). Here, “reconstruction” means enhancement of the procedural implementation of informed consent (how information, support, deliberation, verification, and documentation are organized) rather than a change to the legal doctrine’s core requirements of disclosure, decision-making capacity, voluntariness, and consent.

Within the theory of patient autonomy, the findings affirm that autonomy cannot be understood simply as an individual’s ability to choose after receiving information, because medical decisions occur within relationships involving physicians, families, healthcare institutions, social norms, and the patient’s psychological condition. This understanding expands informed consent from an informative-administrative model toward a relational-deliberative model. The doctrine of medical consent remains relevant because it requires information, decision-making capacity, and voluntariness, but its application to vulnerable patients requires support so that patients are not immediately transferred to substitute decision-makers merely because they experience certain cognitive or communication barriers (Appelbaum et al., 2021). Thus, supported decision-making is not a negation of informed consent, but a reconstruction of the consent process so that it becomes more substantive, inclusive, and legally accountable.

The study also shows that shared decision-making and supported decision-making are conceptually close but not identical. Shared decision-making emphasizes collaboration between patients and healthcare professionals in determining therapeutic choices, whereas supported decision-making emphasizes support for patients so that they remain the primary decision-makers, especially when they face barriers related to understanding, communication, disability, aging, or relational pressure. Comparison with previous literature shows that legal regulation of medical consent is often insufficient to fully institutionalize shared decision-making because questions remain regarding who participates in the decision-making process, what information must be shared, and how legal responsibility is determined when communication is inadequate (Yeoran & Hyuna, 2024). In this context, this article positions supported decision-making as a more appropriate concept for constructing a model of patient legal protection because its emphasis is not only on collaboration, but also on preventing the erasure of the patient’s will.

Relational Autonomy, Power Relations, and Socio-Cultural Context

The interpretation of the literature within the framework of relational autonomy shows that patient decisions are always shaped by social relationships that may be supportive or dominant. Family relationships, support from healthcare professionals, and institutional environments can strengthen patient autonomy when they help patients understand information and express personal values; conversely, the same relationships may hinder autonomy when they become sources of pressure, manipulation, or substitution for the patient's will. A meta-synthesis on relational autonomy shows that supportive relationships, comprehensive information, family pressure, and professional dominance influence how patients exercise autonomy in medical decision-making (Le et al., 2023). Therefore, supported decision-making must be clearly distinguished from practices in which "the family decides for the patient" or "the physician decides for the patient," since both patterns may preserve paternalistic forms that are criticized by modern patient legal protection paradigms.

Comparison with studies from Global South countries shows that family relations, religion, culture, and social structures strongly influence how patient autonomy is understood and exercised. This finding is important for Indonesia, where healthcare takes place in a society that sociologically often positions the family as a significant actor in medical decisions. However, family involvement should not automatically be understood as a violation of autonomy as long as the family functions as a supporter of the patient's understanding and communication, rather than as a substitute for the patient's will. A systematic review of patient autonomy in the Global South shows that social, cultural, religious, and intersectional factors affect healthcare decision-making, making overly individualistic models of autonomy insufficient to explain clinical practice in non-Western societies (Akhtar et al., 2024). This article positions *syūrā* as a corrective to two extremes at once: individualism that ignores the patient's social relations and familial collectivism that erases the patient's will.

In clinical practice, the literature shows that barriers to supported decision-making often arise from power relations in hospitals, particularly professional hierarchy, physician dominance, risk-averse safety culture, and the tendency to assess patient capacity only through cognitive competence. These barriers indicate that strengthening patient decision-making cannot be achieved merely by revising consent forms; it requires changes in clinical communication culture, interprofessional role distribution, and procedures for verifying patient understanding. Studies on assisted decision-making among older patients and persons with disabilities in acute care show that institutional sources of power may restrict patient and family participation in decision-making processes (Donnell et al., 2023). In this article, *syūrā* functions to transform medical communication from a one-way pattern into a deliberative process that requires space for questions and answers, clarification of values, consideration of alternatives, and documentation of patient will.

Findings on patient decision-support instruments show that supported decision-making can be operationalized through concrete methods, such as simple language, information visualization, interview structures, priority cards, simplified consent documents, and patient-centered facilitation. These instruments are important because barriers to decision-making do not always arise from patient incapacity, but often from the way medical information is delivered in technical, rapid, and patient-insensitive forms. The development of enhanced consent procedures for patients with dementia shows that communication aids can help balance autonomy and protection in complex decision-making situations (Wied et al., 2021). Thus, the model offered in this article does not stop at normative ideas, but may be directed toward healthcare procedures involving the identification of patient vulnerability, delivery of understandable information, decision support, clinical deliberation, verification of patient will, and legal documentation.

Integration of *Syūrā*, *Hifz al-Nafs*, and Patient Legal Protection

In palliative care and end-of-life decisions, the literature shows that patients still need to participate in decisions broader than medical procedures alone, including daily care decisions, goals of care, and choices related to quality of life. This is relevant to *hifz al-nafs* because the

protection of life must not be narrowed to the preservation of biological life alone, but must include safety, dignity, personal values, spirituality, and patient welfare. An integrative review of patient participation in shared decision-making in palliative care shows that patients want to be involved in various care decisions and that successful participation requires open communication, interdisciplinary teamwork, good relationships, and a supportive environment (Kuosmanen et al., 2021). In this article, *hifz al-nafs* becomes the basis for directing medical decisions toward the protection of dignified life, rather than merely toward clinical success as judged unilaterally by healthcare professionals.

The relationship between the findings and the Indonesian health law context indicates that patient legal protection must move from a document-based paradigm to a process-based paradigm. If consent to medical treatment is demonstrated only through forms, then understanding, voluntariness, support, and freedom from pressure may not be adequately documented. Studies on the redesign of informed consent regulation in Indonesia show that the main challenge lies in the inadequacy of technical rules regarding information delivery adapted to patient conditions, including patients with disabilities, language barriers, and limited literacy (Masyuri et al., 2024). This article contributes practically by offering supported decision-making as a procedural framework to strengthen the legal evidentiary basis for demonstrating that patient consent is not merely administrative approval, but a decision arising from proper communication, proportional support, and respect for the patient's will. Its legal implication is that policies should define accessible information standards, criteria for patient-designated companions, safeguards against undue influence, verification of understanding, and process documentation, in addition to requiring a signed consent form.

From the perspective of Islamic legal philosophy, the findings show that *syūrā* and *hifz al-nafs* can be integrated without negating patient rights. *Syūrā* is not understood as legitimizing family domination over patients, but as an ethical deliberation mechanism that must keep the patient at the center of decision-making. *Hifz al-nafs* is not understood as a reason to force patients to accept all medical interventions, but as an orientation toward protecting life that must be balanced with patient understanding, proportionality of treatment, prevention of harm, and welfare. In Islamic bioethics, family domination over information concerning the diagnosis and prognosis of a competent patient is considered problematic when it prevents the patient from making decisions based on their own best interests (Alfahmi, 2022). Based on this construction, *syūrā* and *hifz al-nafs* strengthen patient protection because both require communication, honesty, welfare, prevention of harm, and respect for human dignity.

The scientific contribution of this article lies in formulating a conceptual model that connects three domains often discussed separately: health law, theories of patient autonomy, and Islamic legal philosophy. In Islamic bioethics literature, the principles of autonomy, beneficence, non-maleficence, and justice can be contextualized within *maqāṣid al-sharī'ah* through welfare, prevention of harm, trustworthiness, and justice (Rahman et al., 2025). This article extends that direction by positioning supported decision-making as a practical mechanism that bridges these values within the therapeutic relationship. Thus, the contribution of this article is not merely to add an Islamic perspective to health law discourse, but also to make Islamic principles an operational framework for designing medical decision-making processes that are more just, participatory, and legally protected. The resulting scientific contribution is a novel conceptual paradigm of process-based patient legal protection: it operationalizes supported decision-making through *syūrā*-based deliberation and assesses the process against *hifz al-nafs*.

The theoretical contribution of this article is also reflected in its use of *maqāṣid al-sharī'ah* as a framework that does not remain at an abstract level, but is translated into elements of the medical decision-making process. Global bioethics literature shows that Islamic jurisprudential principles, including *fiqh*, *maqāṣid al-sharī'ah*, *maṣlaḥah*, Islamic legal maxims, and the protection of life, can enrich global bioethical discourse, which is often dominated by liberal-individualistic models (Muhsin et al., 2025). In this article, *maqāṣid* is not only used to state that healthcare must protect life, but also to explain how such protection is realized through information provision, accompaniment, deliberation, verification of will, and documentation. This makes *maqāṣid* a normative-procedural framework, rather than merely a general moral principle.

Limitations and Implications

Nevertheless, this study has limitations that must be acknowledged proportionally. First, this article is literature-based and conceptual, and therefore does not provide empirical data on how hospitals, physicians, patients, or families in Indonesia practice supported decision-making in daily healthcare settings. Second, this article has not tested the effectiveness of the proposed model in improving patient understanding, reducing medical disputes, or enhancing the quality of informed consent documentation. Third, *maqāṣid* literature in Islamic medical ethics still faces operational challenges, as some *maqāṣid* models are considered insufficiently detailed to provide direct guidance for clinical dilemmas at the bedside (Padela, 2022). These limitations indicate that the conceptual model proposed in this article requires further validation through empirical research, more detailed normative analysis, and procedural testing in healthcare facilities.

The implication for future research is the need for empirical studies on informed consent practices and patient decision-making in hospitals, especially among vulnerable patients, older patients, patients with communication barriers, persons with disabilities, and patients in high-risk clinical situations. Future studies may also develop an audit instrument for assessing the quality of informed consent based on supported decision-making, which evaluates not only form completeness, but also communication quality, patient understanding, companion involvement, and documentation of deliberative processes. For healthcare practitioners, this article implies the need to develop operational procedures for identifying patient vulnerability, using simple language, involving companions chosen or approved by patients, conducting clinical deliberation, and explicitly documenting patient will. For policymakers, this article points to the need to strengthen technical norms on inclusive medical consent, particularly so that regulation does not only govern the form of consent, but also the standards of communication processes, decision support, protection from pressure, and legal documentation demonstrating that the patient truly remains the primary subject of medical decisions. Future studies should test the model through hospital-based observation, interviews with patients and clinicians, document audits, and comparative evaluation of patient-understanding and voluntariness indicators across vulnerable patient groups.

CONCLUSION

This article concludes that supported decision-making can reconstruct the procedural implementation of informed consent as a model of patient legal protection. The model maintains the patient as the primary decision-maker and comprises understandable information, patient-approved facilitation, protection against domination or substitution of the patient's will, and documented verification of the decision. *Syūrā* operates as the deliberative procedure through which options and values are clarified without displacing the patient's will, while *ḥifẓ al-nafs* operates as the normative orientation toward the preservation of life, safety, dignity, welfare, and the prevention of harm.

The article's contribution is a process-based conceptual paradigm linking health law, relational autonomy, and Islamic legal philosophy. Healthcare policy should specify accessible communication, safeguards against undue influence, patient-approved support, verification of understanding, and documentation of the decision-making process. Future research should conduct hospital-based empirical and normative validation of the model, particularly among patients with disabilities, communication barriers, older adults, and those with high-risk clinical conditions.

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AUTHOR CONTRIBUTION STATEMENT

The authors contributed collaboratively to the conceptualization, literature analysis, development of the theoretical framework, and preparation of the manuscript. All authors participated in reviewing and refining the arguments, ensuring the accuracy of the analysis, and approving the final version of the manuscript. All authors are responsible for the integrity and scholarly content of this article.

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