

ISLAM, HEALTHCARE ETHICS, AND HUMAN RIGHTS

Dr. Mehrunisha Suleman and Arzoo Ahmed

INTRODUCTION

Until recently, medical practitioners had been the principal decision makers within the clinical context globally. This authority was often linked to their superior knowledge, training, and experience in disease pathologies, management, and prognosis. More recently, however, the moral authority of health services and health service personnel, particularly doctors, is on the decline.¹⁵² This is as a result of recent and historical breaches in ethical conduct¹⁵³ that enraged the public and health professionals alike, who are calling for better regulation over the medical community. These violations stimulated a paradigm shift in the moral thinking about the rights and responsibilities of both medical practitioners and patients within contemporary medical ethics. Such shifts run alongside globalized efforts to protect individual freedoms and rights.¹⁵⁴

These transformations are in keeping with Islamic teachings, whose Hippocratic Oath-equivalent (based on the teachings of the Quran and sayings of Prophet Muhammad) insists that medical practitioners serve “all of mankind, poor or rich, literate or illiterate, Muslim or non-Muslim, black or white with patience and tolerance, with virtue and reverence, with knowledge and vigilance.”¹⁵⁵ Exhortations towards the embodiment of virtues and respect for human persons are central to Islamic understandings of the rights and responsibilities of all, including patients and practitioners.

However, despite the work that has been accomplished thus far in contemporary medical ethics in deriving, applying, and reviewing ethical principles, many protocols and the practitioners who apply them fail to take into consideration a key human right. The pertinence of religious pluralism, cultural differences, and

moral diversity that pervade different societies¹⁵⁶ may be overlooked in existing guidance and practice. This chapter will present a summary of some of the Islamic rights of medical practitioners and patients that are currently under-supported within the contemporary medical ethics discourse. A recognition and reinvigoration of supporting patients’ and practitioners’ rights to practice their faith would assist in upholding human rights, especially those ensuring religious and cultural freedoms for all, as articulated in Article 18 of the United Nations’ Universal Declaration of Human Rights, or UDHR. Such a course of action is widely applicable across contexts: where Muslims are majorities, such as in the Arab world, where Muslims exist as demographic minorities, such as in the United Kingdom—indeed, all around the globe.

ISLAMIC RIGHTS OF MEDICAL PRACTITIONERS

Protection of Faith & Life and Conscientious Objection

Islam provides its adherents with a moral road map for their personal, social, and professional spheres. Muslims receiving and providing healthcare thus navigate carefully whether their practice within their professional sphere is in keeping with the sharia (Islamic law). The ethico-legal framework delineated by Islam’s normative sources juxtaposes with global health priorities, secular healthcare systems, and patient preferences. Such factors may require Muslims to navigate between multiple moral spheres.

For example, two key principles exhorted within the Islamic tradition are the “protection of faith” and “protection of life.” These are the first two of five objectives of Islamic Law (Maqasid al-Sharia).¹⁵⁷ Upholding these objectives is central to the Muslim practitioners’ moral obligations and may manifest in their conscientious

152 Kurt C. Stange, “Power to Advocate for Health,” *Annals of Family Medicine* 8.2 (2010): 100-107.

153 Robert Jay Lifton, “Doctors and Torture,” *New England Journal of Medicine* 351, no. 5 (2004): 415-416.

154 United Nations, *Universal Declaration of Human Rights*, adopted December 10, 1948, http://www.ohchr.org/EN/UDHR/Documents/UDHR_Translations/eng.pdf.

155 Ibrahim M. Khan, “Oath of Hippocrates Updated by Muslim Physicians,” *Plastic and Reconstructive Surgery* 83, no. 3 (1989): 579-580.

156 Chris Durante, “Bioethics in a Pluralistic Society: Bioethical Methodology in Lieu of Moral Diversity,” *Medicine, Health Care and Philosophy* 12, no. 1 (2009): 35-47.

157 The other three are protection of intellect, progeny, and property.

refusal to participate in emerging medical interventions. For instance, legislation permitting assisted dying has transformed normative ethical practices within healthcare.¹⁵⁸ Such transitions are a result of the shifts described above, with growing emphasis in healthcare on the patient's rights to autonomy or "self-rule"¹⁵⁹; the latter, having roots in the liberal tradition, emphasizes individual freedom.¹⁶⁰ Muslim practitioners may experience moral dissonance when considering respect for a patient's wish to end their life, for example, with that of their own moral right to protect life and their own faith.

Additionally, emerging challenges related to genetic technologies, the status of the embryo, and embryonic storage, research, and disposal all raise critical moral problems for Muslim medical practitioners. While devoted to the generation of knowledge and therapeutic interventions, they are committed to preserving faith and life and ensuring they are not complicit in moral infringements defined by their faith, similar to adherents of Christianity and other faith traditions.

Policy Suggestions

Although conscientious objection is a recognized practice within healthcare,¹⁶¹ little is known about the impact of this practice on the training and career progression of Muslim healthcare professionals (related to Maqasid principles 3 and 5). With growing calls to reassess the moral status of conscientious objection within the medical practice,¹⁶² more research and engagement is necessary from faiths like Islam to evaluate the transformative interaction between the rights of medical practitioners and patients as well as the moral demands of emerging medical interventions on adherents of the faith. Empirical research in Muslim-majority and Muslim-minority settings is necessary to evaluate whether Muslim practitioners can conscientiously object to participating in interventions they deem to be infringements of their faith. It would be pertinent to assess the nature of their objections and the extent to which those objections are rooted in faith. It would also

be important to analyze whether such practitioners are supported in their actions or if they face stigma or untoward repercussions.

Such research can be used to inform the prevailing medical ethics discourse¹⁶³ as well as accepted medical practice to ensure the rights of medical practitioners wishing to observe their faith commitments are respected.

ISLAMIC RIGHTS OF PATIENTS

Protection of Faith at the End of Life

Ensuring that patients can make informed decisions about their care and that their religious and spiritual needs are met has seen growing importance within contemporary medical ethics over recent years. Such a value is in keeping with the Islamic rights of patients to practice their faith in a state of health or illness. Understanding faith communities' religious and spiritual needs as they interface with the healthcare setting, however, is poorly understood. The biomedical paradigm of understanding health and disease is the prevailing epistemic model within healthcare.¹⁶⁴ George Engel's¹⁶⁵ pioneering paper revolutionized research and practice within biomedicine away from biological reductionism to one that incorporates social, psychological, and behavioral dimensions of illness. Yet there is currently little scope for accommodating patients' metaphysical commitments within the existing biomedical framework. The healthcare context is rarely a sterile and controlled environment; commonly it consists of plurality, diversity, uncertainty, and fragmentation. Healthcare providers, patients, and families who interact within such a context—be that within an institution or in the community—display not only biomedical parameters of symptoms and disease, but also individual and sociocultural histories, languages, values, and beliefs.

158 G. Bosshard et al., "A Role for Doctors in Assisted Dying? An Analysis of Legal Regulations and Medical Professional Positions in Six European Countries," *Journal of Medical Ethics* 34, no. 1 (2008): 28-32.

159 R. A. Hope, Julian Savulescu, and Judith Hendrick, *Medical Ethics and Law: The Core Curriculum* (New York: Elsevier Health Sciences, 2008), 40.

160 John Stuart Mill, *On Liberty* (London: Longmans, Green, Reader, and Dyer, 1869).

161 Mark R. Wicclair, *Conscientious Objection in Health Care: An Ethical Analysis*, (New York: Cambridge University Press, 2011).

162 Julian Savulescu, "Conscientious Objection in Medicine," *BMJ: British Medical Journal* 332, no. 7536 (2006): 294; Ronit Y. Stahl and Ezekiel Emanuel, "Physicians, Not Conscripts—Conscientious Objection in Health Care," *New England Journal of Medicine* 376, no. 14 (2017): 1380-1385.

163 Although there is a substantial discourse on conscientious objection, most of the literature is based on the Christian tradition. There is a paucity of research and literature from the Muslim perspective.

164 This model of health and disease focused on physical systems where an understanding of illness was limited to individual physical symptoms and disease pathology.

165 George L. Engel, "The Need for a New Medical Model: A Challenge for Biomedicine," *Science* 196, no. 4286 (1977): 129-136.

For example, within palliative and end-of-life care, evidence suggests there is a schism between the current model of care and the health needs of religious-ethnic minority populations like Muslims. Such evidence includes reports that point to an unmet need among Muslims of palliative and end-of-life-care services. This is reflected in poor uptake of advanced care planning and hospice services, including community-based services and on-site care. Reports also suggest that services are not adequately equipped to provide care for religious-ethnic minorities, whose spiritual needs are central to their end-of-life care.¹⁶⁶ Healthcare professionals may encounter such beliefs and practices when caring for Muslim patients and families. Without a deep understanding of such commitments, however, tensions may arise in clinical care settings and decision-making. For example, Muslims believe in a life after death and consider death not as an end but a transition.

Many Muslims are devoted to ensuring that this transition is completed in accordance with their spiritual commitments, which include particular beliefs around what constitutes a “good” death, the role of suffering at the end of life, and the spiritual significance of the proclamation of faith by the dying. The Prophet Muhammad said: “Prompt your dying ones to say there is none worthy of worship except Allah” (La ilaha illallah).¹⁶⁷ Such traditions signify the importance of reciting the testimony of faith at the time of death and its significance within Muslim understandings of a good death alongside the recitation of the Quran and positioning of the dying towards Makkah.¹⁶⁸ These beliefs are manifest in the healthcare setting as expressed choices, namely reluctance around the acceptance of pain relief, particularly opiate use at the end of life. Such commitments and wishes may be discordant with the prevailing practices of keeping a patient as comfortable as possible and healthcare professionals’ own assurances to providing evidence-based care.

RECOMMENDATIONS

- Improving religious literacy within the healthcare policy and practice settings, and adapting training on diversity and equality and unconscious bias such that these can offer specific guidance on religious-ethnic populations, may be a step towards equipping staff with the necessary awareness and skills to better understand and in turn accommodate patients’ religious commitments. Such training ought to include demographic data on religious-ethnic populations and up-to-date social science research, such as that conducted by Tayeb et al.¹⁶⁹ on patients’ religious commitments and preferences.

Right to Healthcare

There are many verses in the Quran and sayings of Prophet Muhammad¹⁷⁰ emphasizing health and well-being as a blessing and illness as a test. The sources exhort the status of the ill, saying that those who are sick have the right to be cared for and those who are in a position to do so have a duty to care for them. Illness and disease within an Islamic worldview are understood as suffering incurred by believers as a means of spiritual cleansing where religious transgressions are manifest as ailments, or a means of elevating the devotee. The Prophet Muhammad explained: “There is no disease that God has created, except that He also has created its treatment”¹⁷¹ and that “it is cured with the permission of God.”¹⁷²

Within an Islamic paradigm, therefore, the sick have a right to healthcare and those in a position to offer the care, through resources, skills, and time, are duty-bound to provide it. Imam Ghazali deemed the provision of healthcare a *fard kifaya*,¹⁷³ an obligation on an entire community that can be discharged by a few. These may include individuals and institutions that

166 Natalia Calanzani et al., *Palliative and End of Life Care: For Black, Asian and Minority Ethnic Groups in the UK*, King’s College London, Cicely Saunders Institute, June 2013, https://www.mariecurie.org.uk/globalassets/media/documents/who-we-are/diversity-and-inclusion-research/palliative-care-bame_full-report.pdf.

167 Sunan an-Nasa’i, Book 21, Hadith 9, last accessed May 31, 2018, <https://sunnah.com/nasai/21/9>.

168 Mohamad A. Tayeb et al., “A ‘Good Death’: Perspectives of Muslim Patients and Health Care Providers,” *Annals of Saudi Medicine* 30, no. 3 (2010): 215.

169 Ibid.

170 Sahih Bukhari, Book 75, Hadith 2, last accessed May 31, 2018, <https://sunnah.com/urn/52930>; and Sahih Bukhari, Book 81, Hadith 1, last accessed May 31, 2018, <https://sunnah.com/bukhari/81/1>.

171 Sahih Bukhari, Book 76, Hadith 1, last accessed April 28, 2018, <https://sunnah.com/bukhari/76/1>.

172 Sahih Muslim, Book 39, Hadith 95, last accessed April 28, 2018, <https://sunnah.com/muslim/39/95>.

173 Aryn B. Sajoo, *Muslim Ethics: Emerging Vistas* (New York: IB Tauris, 2008), 109.

comprise a holistic healthcare system, such as health-care professionals, policy makers, and state-level funding levers, such as social health insurance policies.

RECOMMENDATIONS

Islamic ethical teachings on the obligation to protect life and to ensure care for the sick resonate with UDHR Article 25, 1.¹⁷⁴ Such teachings can be made central to the policies and practices of governments of Muslim-majority countries that seek to uphold Islamic ethical values. This can be achieved through the establishment of universal access to healthcare. In particular, governments and policy makers ought to ensure distributive justice to safeguard against the enhancement of inequalities through infrastructural changes and the myriad possibilities for treatment offered by advancing medical technologies. This can be achieved by ensuring that those who are most in need and/or face barriers to accessing care, such as those in remote areas or extreme poverty, are proactively identified and cared for. For example, nation states can ensure a ring-fenced national Waqf (endowment) fund towards free healthcare for individuals and families from lower socioeconomic backgrounds, migrant communities, those with disabilities and learning needs, women, children, and the elderly. Additionally, given the rising healthcare costs globally, healthcare funding for those in need ought to also be allocated from national zakat funds.

Right to Privacy

The cornerstone of patient trust in the medical practitioner and the healthcare profession is the assurance of privacy.¹⁷⁵ A patient's right to privacy and a healthcare professional's responsibility to ensure confidentiality is integral to medical ethics. Biomedicine, however, has transformed dramatically in recent decades. Encounters with healthcare are no longer limited to the individual patient-doctor interface. Nor is information about the patient limited to a case file in a single computer or filing cabinet.

With the advent of population health records, human genetic studies, and big data institutes, governments and corporations now have unprecedented access to individual and population-level data. The public and professionals alike are enthralled by the promise of revolutionizing research through the establishment of such large datasets, and the potential for developing personalized therapies. However, there are pressing ethical questions around privacy and ownership. Individuals making decisions about offering their genetic data for research today are not simply making a personal choice. Their existing relatives as well as future generations co-own the information they provide.

Within Islamic ethics, privacy and trust are greatly emphasized,¹⁷⁶ particularly in relation to the protection of future generations (related to Maqasid, principle 4). The Quran reads: "O you who believe! betray not the trust of God and the Messenger, nor misappropriate knowingly things entrusted to you."¹⁷⁷

RECOMMENDATIONS

More engagement is required from the Islamic scholarly sphere as well as policy makers, public health professionals, and the health industry to assess the moral and legal implications of the collection, storage, and use of big data. This can be achieved through government-level commitments to funding interdisciplinary meetings, research, academic publications, reports, public engagement, and outreach. Such commitments are applicable in Muslim-majority contexts, such as various Middle Eastern states and South Asian countries including Pakistan and Bangladesh—as well as in Muslim-minority contexts, such as those that exist across Europe and North America.

Faith traditions like Islam that emphasize the virtue of privacy may offer much needed guidance and layers of complexity to the existing bioethical discourse on the levels and types of protections that ought to be observed when handling population-level and/or genetic data.¹⁷⁸ Governments should ensure appropriate

174 UNHR Article 25, 1, states that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control." See "Article 25: Right to an Adequate Standard of Living" in *Universal Declaration of Human Rights*, via Claiming Human Rights, A joint project of the National Commissions for UNESCO of France and Germany, adopted December 10, 1948, http://www.claiminghumanrights.org/udhr_article_25.html.

175 Alan G. Johnson and Paul R.V. Johnson, *Making Sense of Medical Ethics: A Hands-On Guide* (New York: Oxford University Press, 2007), 101.

176 Fatimah Abdullah, "Teaching Islamic Ethics and Ethical Training: Benefiting from Emotional and Spiritual Intelligence," *International Journal of Humanities and Social Science* 2, no. 3 (2012): 224-230.

177 Quran 8:27, last accessed April 29, 2018, <http://corpus.quran.com/translation.jsp?chapter=8&verse=27>.

178 Saeid Nazari Tavaokkoli, Nasrin Nejadisarvari, and Ali Ebrahimi, "Analysis of Medical Confidentiality from the Islamic Ethics Perspective," *Journal of Religion and Health* 54, no. 2 (2015): 427-434.

expert (including diverse actors such as faith leaders) and public engagement is carried out when determining the level and types of governance processes and assurance that ought to be implemented when setting up and running big data institutes. Given the unknowable negative implications that may be incurred by future generations, the precautionary principle ought to be observed.

Protection against Exploitative Practices with Growing Research in Muslim Contexts

The globalization of clinical trials has resulted in an increase in research being conducted in low- and middle-income countries (LAMICS). The majority of the fifty-seven Organisation of Islamic Cooperation¹⁷⁹ countries fall within the bracket of LAMICS. Muslim-majority countries in the Southeast Asia (SEA) region, such as Indonesia and Malaysia, have become popular localities for industry- and government-sponsored trials. The latter are increasing in popularity because the trial process has been found to be cheaper, with faster recruitment of participants.¹⁸⁰ However, some authors suggest that one reason for the outsourcing of clinical trials is to avoid the rigorous governance mechanisms present in source countries.¹⁸¹ In addition to the SEA region, the Middle East has also become a popular site for research due to good infrastructure, increased investment in the medical sciences, and burgeoning economies.¹⁸² Research shows that countries in the Middle East also operate with fewer restrictions and so are popular with pharmaceutical companies to trial¹⁸³ new and untested drugs.¹⁸⁴

Islamic ethical teachings emphasize the protection of the weak and vulnerable. Although medical research is necessary for the generation of knowledge and the development of novel preventative and therapeutic interventions, these should not be prioritized over the safety and interests of research participants.

RECOMMENDATIONS

The increase in clinical trials in the LAMICS emphasizes the need for source and host governments to ensure that host sites have robust governance processes in place. The establishment of research ethics governance systems that can successfully oversee research and its development requires both intellectual and infrastructural investment. Islamic teachings that stress protections for the weak and vulnerable would provide an essential component to such guidance and practices.

Another important consideration is that recent work on global biomedical ethics has transformed dramatically, considering not only challenges in consent procedures¹⁸⁵ related to biomedical research, but also more subtle questions relating to exploitation, the need for research to be responsive to local population needs, and the sustainability of research. Currently it appears that there is little engagement from the Islamic scholarly sphere on such pressing moral challenges, and suitable institutions and individuals ought to be supported to engage with such discussions. For example, countries that conduct biomedical research ought to have in parallel a department specialized in bioethics research, including the training and establishment of scholars who are experts in offering Islamic perspectives on the complex questions posed by global health research.

More work needs to be done to enhance global governance efforts to ensure the safety of participants and populations in host countries, such as the establishment of an international legal standard for research ethics. Additionally, a global fund to support legal proceedings against misconduct may enable countries to pursue legal action against industry and research institutions that fall foul of international standards, without fear of undue financial burdens. It would be particularly advisable for Muslim communities with disproportionately high levels of wealth, such as specific Arab states in the Gulf, to contribute significantly in this regard.

179 The organization was formed to promote cooperation between countries with an Islamic identity. It identifies its mandate as: “the collective voice of the Muslim world. It endeavors to safeguard and protect the interests of the Muslim world in the spirit of promoting international peace and harmony among various people of the world.” See “History,” Organisation of Islamic Cooperation, https://www.oic-oci.org/page/?p_id=52&p_ref=26&lan=en. The organization’s mandate has been extended to embrace cooperation in the matter of health as well.

180 Gross Amess and Hirose Mimoko, “Conducting Clinical Trials in Asia,” Pacific Bridge Medical, March 1, 2007, http://www.pacificbridgemedical.com/publications/asia/2007_conducting_clinical_trials; Seth W. Glickman et al. “Ethical and Scientific Implications of the Globalization of Clinical Research,” *New England Journal of Medicine* 360, no. 8 (2009): 816-823.

181 30 Volnei Garrafa et al., “Between the Needy and the Greedy: The Quest for a Just and Fair Ethics of Clinical Research,” *Journal of Medical Ethics* 36, no. 8 (2010): 500-504.

182 Kermani F., “How to Run Clinical Trials in the Middle East,” *SCRIP* (2010): 1-8.

183 Often, it involves testing existing drugs for their efficacy on other diseases and/or trials of new and untested drugs.

184 Ghaith Alahmad, Mohammad Al-Jumah, and Kris Dierickx, “Review of National Research Ethics Regulations and Guidelines in Middle Eastern Arab Countries,” *BMC Medical Ethics* 13, no. 1 (2012): 34.

185 Benjamin Freedman, “Scientific Value and Validity as Ethical Requirements for Research,” *IRB* 9, no. 6 (1987): 7-10.

Conclusion

The discussions above emphasize the ever-increasing ethical concerns that pervade healthcare. As biomedical ethics is only one of many worldviews for understanding and responding to such ethical challenges, faith traditions like Islam play a key role in further elaborating these challenges and providing novel local and global responses to them. From their inception—through the Quran, traditions of the Prophet, and scholarly engagement—Islamic values have remained pertinent to the field of health and wellbeing. These Islamic values interact with and raise ethical questions within the biomedical sphere at multiple levels, including research, development, and the practice of medicine. These values and concerns have been shown to be not only

complementary but also essential in ensuring that the field of biomedical ethics remains conscious of and responsive to religious pluralism, cultural differences, and the moral diversity that pervade societies globally.

Faith traditions like Islam—and the beliefs and practices associated with them—offer much needed guidance on how we ought to think about professionalism, end-of-life care, rights to healthcare and privacy, and exploitation. These specific cases demonstrate the need for symbiosis between religious and biomedical scholarship. The cases also highlight that equipping our collective consciousness through other ways of knowing and practicing, beyond biomedicine, may help us develop a more holistic vision of health and illness and how it is we ought to organize healthcare globally.