PAPER

What is it to practise good medical ethics?
A Muslim’s perspective

G I Serour

ABSTRACT
Good medical ethics should aim at ensuring that all
human beings enjoy the highest attainable standard of
health. With the development of medical technology and
health services, it became necessary to expand the four
basic principles of medical ethics and link them to
human rights. Despite the claim of the universality of
those ethical principles, their perception and application
in healthcare services are inevitably influenced by the
religious background of the societies in which those
services are provided. This paper highlights the
methodology and principles employed by Muslim jurists
in deriving rulings in the field of medical ethics, and it
explains how ethical principles are interpreted through
the lens of Islamic theory. The author explains how, as a
Muslim obstetrician-gynaecologist with a special interest
in medical ethics, including international consideration of
reproductive ethics issues, he attempts to ‘practise good
medical ethics’ by applying internationally accepted
ethical principles in various healthcare contexts, in ways
that are consistent with Islamic principles, and he
identifies the evidence supporting his approach. He
argues that healthcare providers have a right to respect
for their conscientious convictions regarding both
undertaking and not undertaking the delivery of lawful
procedures. However, he also argues that withholding
evidence-based medical services based on the
conscientious objection of the healthcare provider is
unethical as patients have the right to be referred to
services providing such treatment.

Health as defined in the WHO constitution is a
state of complete physical, mental and social well-
being and not merely the absence of disease or
infirmity. The highest attainable standard of health
is a fundamental right of every human being
without distinction of race, religion, political belief,
economic or social condition. Good medical ethics
aims to ensure that all human beings enjoy the
highest attainable standard of health without dis-
tinction on any basis. Huge disparities exist in
healthcare services and their quality between the
North and the South and between the rich and the
poor, which violates the basic ethical principles of
justice, equity and equality: “of all the forms of
inequality, injustice in healthcare is the most shock-
ning and inhumane” (Martin Luther King, Jr.). Despite
the claim of the universality of the four
prima facie ethical principles, their perception and
application must be influenced by the social, cul-
tural, legislative and religious backgrounds of
different societies. In this paper I shall discuss
some global developments in international and
intercultural medical ethics, Islamic perspectives of
medical ethics, the application of good medical
ethics in some specific instances of healthcare pro-
vision, and conscientious objection to treatment.

DEVELOPMENTS IN INTERNATIONAL AND
INTERCULTURAL MEDICAL ETHICS
In any learned profession, specific standards of
conduct which guide the behaviour of its members
are established in codes of ethics. To underpin
such codes in medical ethics, Beauchamp and
Childress in the late seventies proposed the widely
adopted four prima facie ethical principles of ben-
eficence, non-maleficence, justice and autonomy. The
International Association of Bioethics defined
bioethics as the study of ethical, social, legal, philo-
sophical and other related issues arising in health-
care and biological sciences. Because of rapid
advances in scientific knowledge and technology
and their impact on the quality of health services
provided, it became necessary to enormously
expand the four ethical principles of the seventies.
In 2005, the Universal Declaration on Bioethics
and Human Rights was developed by UNESCO
and adopted by United Nations Member States.
Articles 3–17 of the Declaration outlined many
other ethical principles in addition to the four pre-
viously established and linked all to human rights.
These principles included human dignity and
human rights, benefit and harm, autonomy and
individual responsibility, consent, special concern
for persons without the capacity to consent, respect
for human vulnerability and personal integrity,
privacy and confidentiality, equality, justice and
equity, non-discrimination and non-stigmatisation,
respect for cultural diversity and pluralism, solidar-
ity and cooperation, social responsibility and
health, sharing of benefits, protecting future gen-
erations, and protection of the environment, bio-
sphere and biodiversity. Bioethics has been defined
by WHO as a field of ethical enquiry that examines
ethical issues and dilemmas arising from health,
healthcare and research involving humans, thus
highlighting the importance of health research
ethics.

Societies differ in their practice of medical ethics,
differences that are most often based on cultural,
religious, social, bioethical and legal norms. Such
diversity is strikingly apparent in assisted reproduc-
technology (ART) within member states of the
European Union. Progressive Scandinavian coun-
tries such as Norway and Sweden have enacted
restrictive ART legislation against both third-party
donation and surrogacy. On the other hand, Spain,

a traditionally Catholic country with a large Muslim population, is now the European centre for cross-border ART because it allows third-party donation.7 Likewise, third-party ART is provided in Lebanon to both Muslims and Christians, but not in neighbouring Egypt or Italy.8

Even in secular societies, principles, values and beliefs are corporately held by communities and transmitted as part of their culture. When some principles are given absolute value in an authoritarian community, prohibition follows, as in some Catholic societies. We should then be aware of the risk to women’s and newborns’ health when laws on human reproduction are modelled on the values of theologians rather than on evidence-based science and respect for and protection of the human rights of women.9 However, when general principles are given a high but presumptive value, and moral emphasis rests less on religious authority and more on reasoned appeal to conscience, the way is open for moral reasoning to establish greater tolerance of individual moral decision-making. However, such diversity highlights the need for ethicists and practitioners to understand and be tolerant of the complex interactions between culture, religion, local morality and legislation when addressing these medical practices through the lens of global bioethics.

ISLAMIC PERSPECTIVES ON MEDICAL ETHICS

Science and religion have been inter-related since the beginning of human history. As we celebrate the journal’s 40th anniversary, we cannot deny that the past four decades have witnessed the secularisation of bioethics and a decline in religious influence in the field of ethics, which has become dominated by philosophical, social and legal concepts.10 However, in many parts of the world and particularly in the Middle East, religion is still widely meaningful and influences many behaviours, practices and policies. This also applies to many observant followers of various religions living around the globe. Medical ethics are based on the moral, religious and philosophical ideals and principles of the society in which they are practised. It is therefore not surprising to find that what is ethical in one society may not be ethical in another society. With globalisation, healthcare providers (HCPs) and patients alike are moving around to different parts of the world, and it is not uncommon for HCPs to provide medical services to patients with ethical values different from their own. Providing an enlightened insight into Islamic medical ethics will help clinicians, Muslims and non-Muslims, be more knowledgeable when communicating with their Muslim patients. Such informed counselling is important to ensure better concordance with treatment and provision of a quality healthcare service which is culturally sensitive.

Deriving ethical principles

Few publications discuss the methodology and principles employed by Muslim jurists in deriving rulings in the field of medical ethics. Bioethical principles have been interpreted through the lens of Islamic ethical theory, identifying the evidence using an approach frequently employed among Muslims.11 12 In Islam there is no central authority as in the Catholic religion and truly ethical conduct consists of personal searching for relevant values that lead to an ethically inspired decision. Muslims need to distinguish between medical ethics and humanitarian consideration on the one hand and religious teachings and national laws on the other.

The primary and most authentic source of rulings and principles in Islam is the Holy Quran. Muslims believe that the Quran is the word of God revealed to the Prophet Mohammed, praise be unto him (PBUH), via the archangel Gabriel. The revelation of the Quran to the Prophet Mohammed (PBUH) began in 610 AD and continued over 23 years. Under changing circumstances, the rulings given in the Quran may have differed. Thus the context for the ruling has to be taken into consideration in such cases.13 During the reign of Abu Bakr, the first Islamic ruler after the Prophet (PBUH), the Quran was collected and kept in one place. Uthman, the third Islamic ruler, made a number of copies of the Quran which were distributed to different parts of the Muslim world. Therefore, there is one version of the Quran which preserves its authenticity throughout time. The Quran is not simply a book of rituals. It is a book of guidance and has its own method of persuasion and dissuasion, instilling the desire for reward and the fear of punishment. It presents rules of conduct in a language and context that appeal to the emotions, conscience, mind and belief in God.13

The set of instructions which regulates the everyday activities of life to be adhered to by an observant Muslim is called Shariaa. The primary sources of Shariaa in a chronological order are: the Holy Quran; the Sunna and Hadith, which are the authentic traditions and sayings of Prophet Mohammed (PBUH) as collected by specialists in Hadith; and Igmaa, which is the unanimous opinions of Islamic scholars or Aaimma, and analogy (Kias) for Sunni Muslims or intellect (Aql) for Shiite Muslims, which is the intelligent reasoning used to rule on events not mentioned by the Quran and Sunna by matching against similar or equivalent events previously ruled on. In matters not discussed by primary sources of Shariaa, observant Muslims would refer to secondary sources of Shariaa which include: Istihsan, which is the choice of one of several lawful options, the views of the Prophet’s companions, current lawful customs, public welfare and the rulings of previous divine religions if not contradicted by the primary sources of Shariaa. Shariaa is not rigid and adapts to new emerging situations according to human needs. Islam is a religion of Yusr (ease) and not Usr (hardship) and is directed to the benefit of humanity.14 15

The broad principles of Islamic jurisprudence are permitissibility (Ibaha), unless prohibited by a text, no harm and no harassment, and necessity permits the prohibited and the choice of the lesser harm. Islam has affirmed the importance of marriage, family formation, procreation, purity of lineage, and the preservation and protection of the environment and future generations.15 16

Islamic attitudes to the four prima facie ethical principles first developed in 1979 were discussed in great detail by Serour in 1994,11 and recently by Mustafa in 2014.12 These and almost all the ethical principles in the UNESCO’s Declaration of Bioethics and Human Rights are supported in the primary sources of Shariaa.11 15

Recently there has been justifiable confusion about who speaks for Islam. This explains the huge differences between what Islam says and what some Muslims say and do. Islam differs from some other religions in that there is no central doctrinal authority in Islam after the Prophet Mohammed (PBUH). No one can claim exclusive ownership of the truth about Islam. Eminent religious scholars in the early period of Islam mostly concluded their opinions on various issues arising in everyday life by saying ‘and God knows best’. Islamic clergy only have as much moral authority as the trust people put in their knowledge and honesty.13 Islamic religious scholars often disagree with each other and their differences are considered a mercy (as it accommodates for differences) for Muslims. One eminent scholar said his views are correct but may be wrong and the other’s views are wrong but they may be right! Ultimately it is
the people who have to make responsible decisions, which today we call autonomy. It is implausible to expect that the statements of religious scholars over the past several hundred years should be followed today by all 1 billion 200 million Muslims around the globe. The Holy Quran, and when needed the authentic Hadith of Prophet Mohammed (PBUH), remain the unchallenged supreme authority in Islam.

**GOOD MEDICAL ETHICS REGARDING SOME HEALTHCARE ISSUES**

**Vulnerable groups**

Women, adolescents and children tend to be vulnerable because of social, cultural and economic circumstances and need protection. However, these groups have often been dominated by the paternalism of their HCPs and the power of their male partners. So that quality healthcare services based on ethical principles can be provided, women should have the freedom to decide whether, when and how often to bear children. Women have the right to be informed, to provide/withhold consent, and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice. Obtaining women’s free informed consent or dissent in healthcare services should be a continuing process with the right to withdraw consent at any time. Adolescents and children have the right to have access to information and high quality youth-friendly health services which ensure privacy and protect the confidentiality of all information disclosed. Children should be protected from all harmful practices such as female genital mutilation (FGM) including its medicalisation, as well as all forms of violence and abuse.17 The provision of ethically acceptable healthcare service to pregnant women should take ethical obligations to both the pregnant woman and the fetus into consideration with neither automatically receiving priority.20 Justice implies that all be treated with equal standards irrespective of socio-economic status and that patients have equal access to healthcare without discrimination or coercion.21 When resources are limited, the provision of life-saving healthcare services and tackling public health problems takes precedence over the provision of expensive health technology services such as ART.24

**Assisted reproductive technology**

Because it is expensive, ART, an established treatment for both female and male infertility, is not a priority for many healthcare systems in high or low income countries. This highlights is a striking tension between utility and equity and justice. When resources are limited and basic health services are lacking, implementation of ART would be unjust because it would deprive a major section of the population of life-saving and basic health services.22 However, justice and social responsibility demand that people should not be denied advanced healthcare services on the basis of their social background. A mechanism has to be found to provide advanced medical services for the needy who cannot afford them. The challenging tasks will be to simplify ART so that it becomes affordable in low and middle income countries, with the cost but not the quality reduced, and special attention given to minimising complications such as ovarian hyperstimulation syndrome, multiple pregnancy (MP) and prematurity.23 Some developed countries such as Belgium have a single embryo transfer policy to minimise MP complications. Access to ART is dependent not on the wealth of the country but on the distribution of wealth, as well as social and geopolitical factors.24 Thus ART practices vary markedly in different parts of the world depending on religious, cultural, economic and legislative influences.16 21 24

This has resulted in a growing market for cross-border ART, so-called reproductive tourism, which enables the rich to cross borders to access various types of ART not available in their home countries. Such practices involve discrimination against and exploitation of needy and disadvantaged women.1 For Muslims, if ART is indicated as necessary for a married couple, it is permitted and even encouraged as it preserves humankind.14 24 The Sunni Muslim guidelines emphasise the necessity of maintaining purity of lineage. Thus sperm donation, egg donation or embryo donations are not permitted. Most Sunni scholars would not approve of surrogacy. However, the Shiaa guidelines have opened the door to third-party donation, such as a fatwa from Ayatollah Ali Hussien Khameini in 1999. Egg and sperm donation and surrogacy have gained acceptance among Shiaa Muslims.24 25 Multifetal pregnancy reduction, sex selection for medical and social reasons if it does not involve discrimination against either sex, and pregnancy in postmenopausal women (PPM) using the patient’s cryopreserved oocytes are permitted.26 27 Sex selection is of particular ethical concern when it is driven by value differences ascribed to each sex or that arise from pervasive gender stereotypes.26 It is now possible to have PPM using one’s own cryopreserved embryos, oocytes and autografted cryopreserved ovarian tissue. However, PPM is discouraged in light of the special care necessary for the management of pregnancy in a woman beyond normal childbearing age, and children’s need for parents likely to survive at least into their mid-adolescence. Nevertheless, PPM may be permissible in exceptional cases, if justified there are pressing circumstances, there are minimal risks for mother and child, and the parents have the capacity to discharge child-rearing responsibilities.22 27 This is supported by the verses in the Holy Quran which oblige parents to feed, cloth and care for their newborn in a seemly manner, although no one should be charged beyond their capacity or made to suffer because of their child.28 In support of this argument is the recent removal and placing for adoption of an Italian female child born as a result of cross-border ART to a father aged 70 and a mother aged 57. The Italian courts have said that the decision to remove the child was not due to her parent’s age but was solely motivated by a concern for her welfare because of poor parenting.29

**Safe motherhood**

Marriage, pregnancy and childbirth, and family formation are very important for Islamic society. Islam values motherhood highly as pregnancy and child birth are responsible for the continuation of the human species on earth. Islam supports safe motherhood and the care of pregnant and lactating women as well as child spacing, as outlined in several verses in its primary sources.1 11 13 14 15 28

**Family planning**

Islamic Shariat has called for child spacing and family planning. While the Holy Quran was being revealed, the Prophet (PBUH) learned that his companions (Sahaba) were practising al-azl (coitus interruptus) but did not prohibit it. Thus al-azl for temporary contraception is permissible (ja’iz) and lawful. The majority (jumhour) of jurists agree with that al-azl is permitted.15 Imam Al-Ghazali allowed al-azl, with the wife’s consent, for health and economic reasons and even to preserve a woman’s figure and beauty for the continued enjoyment of her life with her husband. Temporary contraceptives as such pills, IUDs, injectables or other methods are allowed. Permanent contraception is permitted if pregnancy and child birth endanger the life of the mother. A thorough review of the Quran...
Other medical practices

The same methodology is also applicable to derive rulings and ethical guidelines on other medical practices evolving as a result of the application of modern technology, including organ transplantation, genetic testing, stem cell research, embryo research, cosmetic surgery, FGM and euthanasia. Ethical guidelines are issued by scholars and jurists on such practices, not mentioned in the primary sources of Shariaa, by referring to the principles of Islamic jurisprudence and the purposes of the law (Maqasid al Shariaa) which promotes the preservation of religion (din), life (nafs), progeny (nasl), intellect (Aql) and wealth (mal).

CONSCIENTIOUS OBJECTION

Globalisation and the continuous movement of HCPs from one country to another have created situations and dilemmas not previously encountered in traditional medical practice. It is quite common for patients and their HCPs to have different religious and ethical perspectives concerning healthcare services.

The primary ethical commitment of HCPs is to serve their patients’ health and well-being by offering the highest quality and safety of care. HCPs have a duty to inform their patients of all medically indicated options for their care, including those in which they themselves would decline to participate. They should not allow their advice to be influenced by personal beliefs that differ from professionally accepted medical evidence and/or guidelines. If in an emergency, a patient’s physical or mental health, or indeed life, can be preserved only by a procedure to which the HCP object even though the same procedures can be used for medically indicated purposes to which they do not object even though the same procedures can be used for medical indications to which they do object.

HCPs who are postgraduate students or in training have a duty to inform their teachers and/or supervisors of their conscientious objection in a timely fashion, to ensure that alternative arrangements for the appropriate care of their patients can be made. They cannot decline training in procedures performed for medically indicated purposes to which they do not object even though the same procedures can be used for medical indications to which they do object.

HCPs have a right to respect for their conscientious convictions regarding both undertaking and not undertaking the delivery of lawful procedures, and to not suffer discrimination on the basis of their convictions. Their right to respect for their choices regarding medical procedures and care in which they participate also requires that they respect patient choices regarding medically indicated options for their care.

HCPs may sometimes be subject to violence or pressure because they provide evidence-based treatment opposed by some groups or authorities, for instance HCPs have been threatened and attacked for providing pregnancy terminations and recently for administering poliomyelitis vaccination in Nigeria, Pakistan and Afghanistan. It is a professional and societal obligation to advocate for the rights and security of each HCP to practise his/her profession within the law and with protection from interference or intimidation from any source, governmental or non-governmental. This has been emphasised by the Islamic Advisory Group and other religious leaders.

Competing interests None.

Provenance and peer review Commissioned; internally peer reviewed.

REFERENCES

8 Inhorn MC, Patrizio P, Serour GI. Third-party reproductive assistance around the Mediterranean; comparing Sunni Egypt, Catholic Italy and multie sectarian Lebanon. RBM Online 2010;21(1):848–53.