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**ETHICS OF MEDICINE AND HEALTH**

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**ETHICS OF MEDICINE AND HEALTH**  
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**1. INTRODUCTION**

For thousands of years, scientists, sages and healers have struggled with the effects of disease and injury on man's body and mind, and gradually have peeled away those secrets of nature that shrouded our understanding of what causes our health problems.

Huge achievements in science and technology and socioeconomic development have led to better health status in most parts of the world. Morbidity and mortality were reduced and life expectancy increased. Medical progress contributed to alleviate suffering and to decrease disability.

Despite these improvements, modern technology has had some negative side effects, particularly on the arts of healing in both developed and developing countries. Indeed the sophistication of medical interventions has undermined the human dimension of the relationship between healers and patients. The human touch began to wane as patients were increasingly treated as case numbers, just as a mechanic would deal with a particular machine. The same limitation is also witnessed in the wider sphere of society, where little concern is paid to health promotion and protection conducive to better quality of life. Such failures have increased awareness about the need for a revival of fundamental values in health through development of biomedical ethics.

**1.1 What do we mean by ethics?**

Ethics are defined as underlying principles that infuse laws, social customs and the codified rules of professional groups. As a constructive discipline, ethics seek to determine which actions, relationships and policies ought to be considered right or wrong. Ethics "oughts" or "shoulds" need to be convincing. They must be logically consistent, rely upon accurate facts and data, and be capable of universal and impartial application. Principles of right action are found within historic oaths, professional codes and treaties on the ethics of biomedical research. Biomedical ethical issues cut across national boundaries and often have universal implications. Though peoples and cultures differ, certain values are common to all. The most important is human dignity, which should not be negotiable.

**1.2 Principles and sources of health ethics**

Value systems drawn from religious, philosophical, ideological and other cultural systems are the main sources of health ethics, of which bio-ethics are a part. The Eastern Mediterranean Region of WHO is the cradle of three of the major religions (Judaism, Christianity and Islam). These three monotheistic religions have largely similar bio-ethical values, which are the main source of health ethics in large areas of the world.

The following are some of the principles on which general and global consensus is possible even though some differences of detail may exist in some cultures:

- Respect for human life and recognition of the inherent worth and dignity of individuals and their right to confidentiality.
- Respect for persons recognizes all people as autonomous agents and requires that their choices (consent or refusal) be observed.
- Doing good (beneficence) and doing no harm (non-maleficence) are two complementary ethical principles that impose affirmative duties on researchers to maximize any benefits for subjects and minimize risks to them.
- Justice requires that humans be treated equally.

### 1.3 Islam and health ethics

The cardinal ethical principles of medical and health professions form part of the cardinal principles of Islam, as a way of life. These principles are:

- respect of human dignity,
- justice; and
- beneficence.

التكريم والعدل والأحسان

By respect for human dignity we mean that a human being should be treated as a "person", that is to say as an "individual who has rights to claim and duties to perform". This entails independent decision-making and continuous protection of such independence as well as taking full responsibility and accountability.

This is clearly spelled out in the following verses of the Holy Qur'an.

- \* Regarding independent decision-making:

«اعْمَلُوا مَا شِئْتُمْ»

"Do whatever you may wish" [Fussalit: verse 40]

«لَسْتَ عَلَيْهِمْ بِمُصِطِرٍ»

"You are not the one to impose on them" [Al-Ghashiyah: verse 22]

«وَمَا أَنْتَ عَلَيْهِمْ بِجَبَّارٍ»

"You are not the one to compel them" [Qaf: verse 45]

\* Regarding taking full responsibility and accountability:

«كُلُّ امْرِئٍ بِمَا كَسَبَ رَهِيْنٌ»

"Each individual is accountable for his deeds" [Al-Tur: verse 21]

«كُلُّ نَفْسٍ بِمَا كَسَبَتْ رَهِيْنَةٌ»

"Every soul is responsible for its deeds" [Al-Muddathir: verse 38]

«إِنَّ السَّمْعَ وَالْبَصَرَ وَالْفُؤَادَ كُلُّ أُولَئِكَ كَانَ عَنْهُ مَسْئُولًا»

"Hearing, eyesight and mind: all of those  
he shall be accountable for" [Al-Israa: verse 36]

These, which are among the most important Islamic principles, are also among the most principles in dealing with a patient. They imply, in this connection, recognition of a patient's fundamental right as a "person" entitled to rights and committed to duties. Patients have the right to know all details relating to their cases, to receive proper treatment, to have their medical secrets safeguarded, and to obtain adequate care. However, patients enjoying these rights should never cause harm to the community in which they live.

The main social virtue on which a Muslim's conduct is based is collective rather than interpersonal, and this is an essential feature of the Islamic system. Although Islam clearly distinguishes between man as a separate entity and man as a member of the community, these two realities are nevertheless deeply interrelated. From this interrelationship stems the concept that all that is done for the community has a spiritual value for the individual, and vice versa.

In Islam, man is entitled to respect as a human being irrespective of race or religion. A verse in the Holy Qur'an says:

«وَمَنْ أَحْيَاهَا فَكَأَنَّمَا أَحْيَا النَّاسَ جَمِيعًا»

"Who quickens a human being, it shall be as if  
he has quickened all mankind" [Al-Ma'idah: verse 32]

This "quickening" in Islam is not only physical, it is at the same time mental and social.

All members of a Muslim society (including non-Muslims) are considered brothers (in Islam or in humanity) and this brotherhood implies many duties. A brother - to use the words of the Prophet (peace be upon him):

"cares for his brother and protects him" and «يَكْفُ عَلَيْهِ (أَي عَلَى أَخِيهِ) ضَيْعَتَهُ وَيَحُوطُهُ مِنْ وَرَائِهِ»  
"he does not fail or forsake him"<sup>1</sup>. «لَا يُسَلِّمُهُ وَلَا يَخْذُلُهُ»

<sup>1</sup> Narrated in Al Bukhari, Muslim, Abou Dawood, Al Termizi and Ibn Hanbal, by Ibn Omer

One of the main principles in Islam is the care of the aged. To use the words of the second Caliph, "it is unfair to exploit the youth of a human being and then to forsake him when he becomes old".

«فوالله ما أنصفناه إن أكلنا شببته، ثم نخذله عند الهرم».

The other two principles, justice and beneficence, are also among those strongly stressed by Islam. They are mentioned together in the Holy Qur'an:

«إِنَّ اللَّهَ يَأْمُرُ بِالْعَدْلِ وَالْإِحْسَانِ»

"God commands justice and beneficence" [Al Nahl: verse 49]

and they are highly regarded in contemporary medical ethics.

By justice, العدل والقسط we mean equity in meeting needs and in delivering care. In the area of health, "justice" is reflected in maintaining, as much as possible, equality in the distribution of health resources and the provision of preventive and curative opportunities, without discrimination for sex, race, belief, political affiliation, social or other considerations. All people, irrespective of any such factors, should have equal access to primary health care, and preventive and curative services. Needless to say, this is precisely the essence of Health for All, the slogan and concept advocated by WHO.

"Beneficence" الاحسان involves an additional value, namely the noble feeling that it is absolutely essential that one should fulfil one's duty towards one's brothers and sisters in humanity, particularly those who are weak or helpless. It is one's duty to fight to obtain for them their forfeited rights:

«وَمَا لَكُمْ لَا تُقَاتِلُونَ فِي سَبِيلِ اللَّهِ وَالْمُسْتَضْعَفِينَ مِنَ الرِّجَالِ وَالنِّسَاءِ وَالْوِلْدَانَ»

"And why should you fight for God's sake in the cause of the deprived men, women and children". [Al Nisa: verse 75]

Closely related to this is the duty of health care providers who should acquaint their patients of their rights and of how to promote their health and care for themselves before they seek the help of others. Beneficence also entails perfection, as far as possible, both in performance and in kindness. To use the words of the Prophet (peace be upon him): "God has decreed perfection on everything"<sup>1</sup>.

«إن الله كتب الإحسان على كل شيء»

These three cardinal noble values as well as those secondary values deriving from them, were the main pillars on which biomedical ethics were built. In traditional Islamic societies, there was a considerable interaction between the religious scholars and those who practised the healing arts. This interaction was unfortunately disrupted during the colonial era, leading to the adoption by the elite of Western values, while the traditional systems were relegated to the background.

<sup>1</sup> Narrated in Muslim, Abou Dawood, Al Termizi, Al Nassa'i, Ibn Maja and Al Darimi, by Shaddad Ibn Aous

The principles of bio-ethics have undergone fundamental changes in Western society in the last five decades, owing to technological advances, and epidemiological, social and demographic transitions. Changes were also caused by growing population expectations and a tendency to consumerism, which generated many ethical dilemmas. As a result, discussions on ethical matters became popular and passionate. In most European countries, specially appointed independent ethics committees exist to examine all experimental protocols for research on humans. They have entrenched systems for promulgating ethical codes and for enforcing adherence to them. Most have, or are moving towards a system of regional or local ethical committees with responsibility to approve and supervise the conduct of all research involving humans carried out in their locality.

In most developed countries, institutions dealing with bio-ethics were established and the teaching of ethical principles was generalized.

In most developing countries, medical ethics are not a part of mainstream thought, not even in the medical profession. They are referred to briefly whenever an instance of medical negligence or malpractice makes the headlines.

## **2. KEY ISSUES IN BIO-ETHICS AND HEALTH CARE ETHICS**

### **2.1 Medical practice**

In all cultures, from the inception of humanity, medical practice was regulated by codes of ethics. The Hippocratic oath, which is well known to all physicians, is an illustration. The principles embodied in such a code were enriched by religions and cultures. Arabic and Islamic oaths were also developed and are used in medical schools in the Eastern Mediterranean Region.

The value of a healing process that stresses humanity and generosity is well perceived in the following text, quoted from the 13th century physician Salahuddin Ibn Youssuf Al Kahhal<sup>1</sup>, addressed to his students:

"You should know, son, that this vocation is a bonus from God Almighty, donated by him to those who deserve it, as they will become intermediates between the patients and God's healing. In doing your best to elicit a cure for your patients until you restore health to them, you earn not only the confidence of people as a proficient and skilful man but also the reward and recompense from God in the hereafter, because the benefit that reaches out to human beings is very precious, particularly that which goes to the poor and powerless. Not to mention the integrity of character which is the nature of generosity and clemency. Hence you should put on the suit of virtue and chastity, purity and kindness, and fear God, especially when examining the family members, and keep their secrets, be philanthropic and pious, devoted to science and learning heedless of bodily desires, keeping close to scientists, caring for your patient, keen to cure him, attempting to bestow well being on him... even if you have to give the poor patient some of your own money, give it"

<sup>1</sup> Nur Al Uyoun Wa Jam'i Al Funoun

The noble values highlighted in this address should be considered as benchmarks for all practitioners aiming at serving other human beings, particularly those who are vulnerable and poor.

Medical practice in both developing and developed countries is shaped by the level of growth in general and that of science and technology in particular. Spectacular advances in biology, imaging medicine, surgery, etc., have increased patient expectations, and put pressure on physicians and medical societies. Risks are no longer accepted, and physicians are urged to adapt to this new trend by changing treatment procedures. Virtual epidemics of caesarean sections in the U.S.A. are partly a result of an aversion to lawsuits from parents based on delivery complications, however minor. Such practices, added to the high costs of malpractice insurance imposed on physicians, contribute to escalating cost of health care in many developed countries.

Physicians and allied professionals willing to defend their professions and codes of ethics are organized into societies and associations. In many countries these corporations represent a real power, and are involved in all negotiations related to regulatory activities, honoraria and reimbursement mechanisms and codes of medical practice. The ethical codes used by the profession are taught in medical schools in most countries.

The code of ethics for nursing practice was first adopted in 1953 and is periodically reviewed and revised. The International Council of Nurses (ICN), which regards standards of professional practices as the essence of its mission, plays an important role in this respect. In 1977, the ICN published *Nurse's Dilemma: ethical considerations*, which provided members of the profession worldwide with one of the first guidebooks on nurses' ethical decision-making. Ethical decisions are increasingly affected by cultural, religious and political values as well as by nurses' personal values and their perceived professional responsibilities.

The technological developments in health care and the complexity of the working environment of nurses as members of the health team point to the need to promote ethical principles among professionals. Ethics should also be part of the training curricula for nurses and midwives.

## **2.2 Research**

In all societies, advances in medicine are indebted to research and clinical trials. This issue is well illustrated by the Socratic adage "the unexamined life is not worth living", namely that medicine unexamined through systematic research may be a danger to patients. The Holy Qur'an recommends the prayer "O my lord, advance me in the knowledge"<sup>1</sup> and the Prophet Mohammed decreed that "the pursuit of knowledge is a mandate on every Muslim, man and woman"<sup>2</sup>.

All countries subscribe to the idea that research is an essential tool for development. The Organization of African Unity recently exhorted Member States to devote at least 1% of their gross national product to research and development. Research on human subjects is (and has to be) performed in all countries, developed and developing. Ideally, all biomedical research involving human subjects should be conducted in compliance with the three ethical principles: respect for persons, beneficence and distributive justice.

<sup>1</sup> Taha: verse 114

<sup>2</sup> Narrated in Ibn Maja, by Anas ibn Malik



### **Research involving human subjects**

This is the most important area in ethical aspects of health research. A Declaration on the subject was enunciated following the Nuremberg trials. Subsequently the Council for International Organizations of Medical Sciences (CIOMS) and WHO jointly elaborated a code of ethics for clinical research, which was adopted by the Eighth World Medical Assembly in Helsinki in 1964 (the Helsinki Declaration) and revised by the Twenty-ninth World Medical Assembly in Tokyo in 1975 (the Helsinki II Declaration). After considerable consultation with international experts, CIOMS published *Proposed international guidelines for biomedical research involving human subjects* in 1982. These guidelines were revised after further consultations and republished in 1993. As a companion publication *International guidelines for ethical review of epidemiological studies* were issued in 1991. Some of the significant themes in the guidelines are given below.

**Informed Consent:** Freely given informed consent and the liberty to withdraw it at any stage is one of the important conditions for the use of human subjects in research and was stressed, in particular, in the Nuremberg code. However, the application of this important principle in practice presents many difficulties, some of which are as follows:

- a) It is difficult for laymen, especially in rural areas of developing countries, to grasp fully the nature of the experiment or of the risks they incur in being volunteer subjects for research.
- b) "Volunteers" are often easily forthcoming from the poorer (vulnerable) sections of the population and would even risk suffering pain or bearable damage for small payments. It is evidently unethical to exploit the subjects' poverty and vulnerability in this manner.
- c) Medical students, prison inmates and other such groups have frequently been used for medical experiments in exchange for different favours and advantages. The latter tinge the freedom of consent given by these and similar groups.
- d) Children and most mentally defective or ill persons are evidently unable to give informed consent. They should be excluded from research or the consent of their legal guardians obtained instead, if their participation is indispensable.
- e) Pregnant women may be involved in clinical trials by chance or by design. This raises the important issue of effects on the foetus and its development. According to some ethicists, human foetal material may be used only until the foetus becomes potentially viable, but there is no final agreement on the criteria to be used in determining the stage at which it attains viability. Some communities, religious groups and individuals (including physicians) strongly object to the use of the living human foetus or its tissues in scientific work. It is advisable to exclude pregnant and nursing women from research that carries any possibility of risk to the foetus or neonate, unless this is intended to elucidate problems of pregnancy or lactation.
- f) Consent by proxy is sometimes given by a tribal chief or a village headman on behalf of the whole tribe or village. Such consent may be considered to be

valid locally but in actual fact it is not consent by the subject. However, it may be difficult (or even impossible) to obtain informed consent of each member of the community.

### **Community research**

Modern methods of collection, analysis and storage of data on individuals and communities in epidemiological research pose new threats to the rights and freedom of people, and confidentiality. The problem has been accentuated by the HIV/AIDS pandemic, which has generated prejudice and unjustified discrimination against victims of this infection. CIOMS has studied the ethical and moral issues and published guidelines on this subject in 1991. Admittedly, there is no easy resolution of the moral ambiguities involved. However, high professional standards in regard to both humane attitudes and quality of research can greatly ameliorate the situation of individuals and benefit the society.

### **Independent ethical review**

It is clear that the "informed consent" procedure may not be adequate to protect the interests of the subject in many cases. It is also vulnerable to misuse. It is therefore essential that a government or other authority sets up a mechanism to assure that health research is planned, conducted and utilized within the framework of the ethical and moral norms of society. This is done by establishing a national review committee and, if necessary, local committees in universities, lead institutions, etc. They should take necessary action to make sure that:

- the proposed research is justified in terms of the advancement of health knowledge in the interest of the community or a section of it;
- all possible efforts have been made through animal experiments and laboratory tests to define as far as possible the risk of the experimental intervention and that the subjects are kept informed of the consequences of their participation;
- the investigator is suitably qualified to carry out the work and the subject remains under observation of a physician who has the necessary experience and facilities to protect the safety of the subject;
- subjects can withdraw their consent at any stage without prejudice to their interests;
- data concerning the subject are kept confidential, like other medical records;  
and
- the socio-cultural norms of the community are not forgotten.

A review committee should be constituted in such a way that it has access to professional expertise as well as lay opinion and can look after the interests of the community as well as health science. Women should be among the members of the committee.

Several countries of the Eastern Mediterranean Region lack the capacity and mechanisms for ethical review of research. This aspect needs considerable strengthening.

### **Human genetics research**

Discussion of this subject is dominated by the international efforts to map the human genome. Five to ten per cent of the estimated total genes have already been mapped on a specific chromosome region. Among other benefits, this project promises to yield extremely useful information about over 4000 genetic diseases and defects. Most of these are single-gene diseases, such as thalassaemia, sickle-cell disease, cystic fibrosis and Huntingdon's chorea. The new knowledge makes it possible to make an accurate diagnosis at the pre-symptomatic stage (and even prenatally) other diseases with a genetic component, such as coronary heart disease, hypertension, diabetes and certain cancers and mental disorders, may be understood better and prevented or treated (in combination) with gene therapy.

The application of the foregoing knowledge in the diagnosis and screening of genetic diseases already poses problems of protecting the dignity, autonomy and confidentiality of the subject. The 24th CIOMS Conference on Genetics, Ethics and Human Values held in Tokyo and Inuyama City, Japan, in 1991, adopted the **Inuyama Declaration** to deal with these problems.

### **Measuring and valuing human life**

In 1993, the World Bank in its *World Development Report: Investing in health* proposed some innovative methods of quantifying and comparing the burdens of disease borne by different populations. In calculating what was termed "disability adjusted life years" (DALY) and in valuing years of life lost because of premature death, certain assumptions were made which raise serious ethical questions.

Scientists participating in the WHO-CIOMS colloquium on the "Impact of Advances in Science and Technology on the Future of Global Health" held in Charlottesville (USA) in June 1994, expressed serious reservations about the scientific validity of DALY indicator and recommended its critical evaluation. The necessity of developing scientifically valid and ethically acceptable criteria for public health practice and resource allocation was stressed.

### **2.3 Euthanasia**

The definitions of euthanasia are not precise and may vary from one person to another, but some agreement is apparent. Most commentators restrict their description to direct or "active" euthanasia, which can be divided into three categories:

- 1) The intentional killing of those who have expressed a competent, freely-made wish to be killed;
- 2) Professionally-assisted suicide; and
- 3) The intentional killing of newborn infants who have congenital abnormalities that may or may not be threatening to life - often by withholding of nourishment.

The term "passive" euthanasia is misleading and inaccurate. It refers to the following practices which, when properly applied to dying patients, are extensions of good medical care, and are no different in principle from comparable decisions elsewhere in medicine. They are:

The withdrawal of treatment that has proved to be of no benefit;

Not commencing treatment that is judged to be of no benefit; and

The vigorous application of treatment that is necessary to control severe distress, usually pain, although this possibly may shorten life.

Since these decisions may be made close to the end of life, death may follow soon, but not invariably; and because of this some people have labelled these practices too as euthanasia.

The contemporary scholar, Sheikh Yousuf Al Karadhawi was very clear when he discussed this subject<sup>1</sup>. He mentioned that treatment could be considered as recommendable **مستحب** or even mandatory **واجب** if the treatment is promising and recovery is expected. However, if recovery is not expected according to God's laws related to cause and effect which are well-known to the experts and qualified physicians, then nobody will say that this kind of treatment is mandatory or even recommended. He goes on to say that exposing the patient to any kind of treatment, be it oral, parental, alimentation by glucose or attaching the patients to devices which artificially support life functions, will prolong the period of his disease and maintain his/her suffering for a longer period, it is *a fortiori* neither recommended nor mandatory. In such cases, the opposite would be mandatory or recommended. This kind of euthanasia, if the nomenclature is right, should not be classified with what is called "mercy-killing" as there is no active action undertaken by the physician, it is rather the abstention from a measure which is not mandatory nor recommended. It is, therefore, permissible and legitimate though not favoured and the physician can practice it for the sake of the rest of the patient and his family without feeling guilty. As for the withdrawal of life-support systems from a patient who is considered according to the state of art as dead or practically dead, in consequence of the death of the brain stem, Sheikh Al Karadhawi believes that this should not be classified as active euthanasia. This is another form of what is called passive euthanasia, which is permissible and legitimate. As for the other forms of active euthanasia, they are a kind of intentional killing and are, therefore, illicit and prohibited. The Qu'ran says:

"Whoever kills a human soul for other than slaughter or corruption on earth, it shall be as if he killed all mankind".<sup>2</sup> [Al-Ma'idah: verse 32]

« مَنْ قَتَلَ نَفْسًا بِغَيْرِ نَفْسٍ أَوْ فَسَادٍ فِي الْأَرْضِ فَكَأَنَّمَا قَتَلَ النَّاسَ جَمِيعًا »

<sup>1</sup> Contemporary fatwas. Part II.

<sup>2</sup> Narrated in Al Bukhari, Abou Dawood, Al Termizi, Al Nassa'i, Ibn Maja and Ibn Hanbal by Omer Ibn Al Khattab.

As is mentioned in one of the publications of the Islamic Organization for Medical Sciences:

“human life is sacred, and should not be wilfully taken away except upon the indications specified in Islamic jurisprudence, all of which are outside the domain of medical profession” and “a doctor shall not take away life, even when motivated by mercy. This is prohibited because it is not one of the legitimate indications for killing”.

As Brian J. Pollard<sup>1</sup> puts it, the advocates of euthanasia are often adherents of utilitarian schools of thought. For them, the way to assess the morality of an action is to look at its outcome - if the outcome is deemed to be good, the action is good, and vice versa. What is “good” in any context is judged by differing and non-fixed standards, which often are subjective.

However, religion locates morality in the intention of the one who is performing the action *انما الاعمال بالنيات*. The action is sound morally if good was genuinely intended. By this standard, morality is bound up intimately with the concept of God as the creator and law-giver, whose precepts humans should abide.

If one holds that morality is determined by intention, allowing death (that is withdrawing treatment that is sustaining or prolonging life) and direct killing can be separated into two different categories of moral responsibility. Morally, allowing a person to die may be good, neutral or bad, depending on the circumstances; whereas killing with intent is always morally bad. It is well to remember that the law uses the same yardstick of motive (that is, intention) in assessing guilt or otherwise in its civil and criminal jurisdictions.

#### **2.4 Organ transplantation**

The guiding principles to human organ transplantation advocated by WHO in 1991 are given below:

##### **Guiding principle 1**

Organs may be removed from the bodies of deceased persons for the purpose of transplantation if:

- a) Any consents required by law are obtained, and
- b) There is no reason to believe that the deceased person objected to such removal, in the absence of any formal consent given during the person's lifetime.

##### **Guiding principle 2**

Physicians determining that the death of a potential donor has occurred should not be directly involved in organ removal from the donor and subsequent transplantation procedures, or be responsible for the care of potential recipients of such organs.

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<sup>1</sup> *The Medical Journal of Australia*, 149, 19 September 1988, p.317

**Guiding principle 3**

Organs for transplantation should be removed preferably from the bodies of deceased persons. However, adult living persons may donate organs, but in general such donors should be genetically related to the recipients. Exceptions may be made in the case of transplantation of bone marrow and other acceptable regenerative tissues.

An organ may be removed from the body of an adult living donor for the purpose of transplantation if the donor gives free consent. The donor should be free of any undue influence and pressure and sufficiently informed to be able to understand and weigh the risks, benefits and consequences of consent.

**Guiding principle 4**

No organ should be removed from the body of a living minor for the purpose of transplantation. Exceptions may be made under national law in the case of regenerative tissues.

**Guiding principle 5**

The human body and its parts cannot be the subject of commercial transactions. Accordingly, giving or receiving payment (including any other compensation or reward) for organs should be prohibited.

**Guiding principle 6**

Advertising the need for or availability of organs, with a view to offering or seeking payment, should be prohibited.

**Guiding principle 7**

It should be prohibited for physicians and other health professionals to engage in organ transplantation procedures if they have reason to believe that the organs concerned have been the subject of commercial transactions.

**Guiding principle 8**

It should be prohibited for any person or facility involved in organ transplantation procedures to receive any payment that exceeds a justifiable fee for the services rendered.

**Guiding principle 9**

In the light of the principles of distributive justice and equity, donated organs should be made available to patients on the basis of medical need and not on the basis of financial or other considerations.

\* \* \*

The Islamic viewpoint was elegantly expressed by the Islamic Organization for Medical Sciences. The following is a quotation from the booklet, *Topics in Islamic Medicine*, by Dr Hassan Hathout:

"The individual patient is the collective responsibility of society, which has to ensure his health needs by any means, inflicting no harm on others. This comprises the donation of body fluids or organs such as providing blood transfusion to a bleeding person or a kidney transplant to a patient with bilateral irreparable renal damage. This is another *fardh kifaya*—a duty that donors fulfil on behalf of society. Apart from the technical procedure, the onus of public education falls on the medical profession, which should also draw the procedural, organizational and technical regulations and the policy of priorities".

Organ donation shall never be the outcome of compulsion, family embarrassment, social or other pressure or exploitation of financial need.

Donation shall not entail the exposure of the donor to harm.

The medical profession bears the greatest portion of responsibility for laying down the laws, rules and regulations for organ donation during life or after death by a statement in the donor's will or the consent of the family, as well as the establishment of tissue and organ banks for tissues amenable to storage. Cooperation with similar banks abroad should be established on the basis of reciprocal aid.

"Umar ibnul-Kattab, second Caliph, decreed that if a man living in a locality died of hunger being unable of self-sustenance, then the community should pay his money ransom (*fidiah*) as if they had killed him. The similitude of people dying because of lack of blood transfusion or a donated kidney is very close. Two traditions of the Prophet seem to be quite relevant in this respect.. the one is: The faithful in their mutual love and compassion are like the body... if one member complains of an ailment all other members will rally in response.<sup>1</sup> The other tradition says: The faithful to one another are like the blocks in a whole building... they fortify one another.<sup>2</sup>

God described the Faithful in the Qur'an saying: "They give priority over themselves even though they are needy"<sup>1</sup> [Al Haslu: verse 9]. This is even a step further than donating a kidney, for the donor can dispense with one kidney and live normally with the other ... as routinely ascertained medically prior to donation.

If the living are able to donate, then the dead are even more so: and no harm will afflict the cadaver if heart, kidneys, eyes or arteries are taken to be put to good use in a living person. This is indeed a charity ... and directly fulfils God's words: "And who-so-ever saves a human life, it is as though he has saved all mankind" [Al Maidah: verse 32].

<sup>1</sup> Narrated in Al Bukhari, Muslim and Ibn Hanbal, by Al No'man Ibn Bashir

<sup>2</sup> Narrated in Al Bukhari, Muslim, Al Termizi, Al Nassa'i and Ibn Hanbal, by Abou Moussa

A word of caution, however, is necessary. Donation should be voluntary by free will ... or the dictatorships will confiscate people's organs, thus violating two basic Islamic rights: the right of freedom and the right of ownership.

In the society of the Faithful donation should be in generous supply and should be the fruit of faith and love of God and His subjects. Other societies should not beat us to this noble goal.

## 2.5 Acquired Immunodeficiency Syndrome

In a symposium on "AIDS-related social problems from an Islamic Perspective" held in December 1993 in Kuwait by the Islamic Organization for Medical Sciences in collaboration with the WHO Regional Office for the Eastern Mediterranean and the Academy of Islamic Jurisprudence, WHO presented a background document, of which we quote the following: "It is not necessary for every AIDS patient to have committed the sin of adultery; one may have contracted the disease as a result of a blood transfusion with contaminated blood, another could be the faithful spouse of a sinful one who has transmitted the infection to him".<sup>1</sup>

Nevertheless, even those who have committed the sin should not be cast out of the realm of Islam, particularly after they have been afflicted with the disease and started suffering its distress.

The Prophet (Peace be upon Him) also said: "Whosoever relieves his distressed brother in this world, God shall relieve him of distress on the Day of Judgement. And he who protects the confidentiality of a Muslim shall be protected by God in this world as well as in the life that comes".

« من نفس (وفي رواية فرج) عن أخيه كربة من كرب الدنيا، نفس (وفي رواية فرج) الله عنه كربة من كرب يوم القيامة، ومن ستر مسلماً ستر الله عليه في الدنيا والآخرة. »

The Prophet (Peace be upon Him) also said: "The Muslim is a brother to each Muslim. He may not wrong his brother nor may he give him up unto harmful hands or harmful conditions"; in another version: "nor may he forsake him".<sup>2</sup>

« المسلم أخو المسلم لا يظلمه ولا يسلمه، »، وفي رواية « ولا يخذله »

Also said by the Prophet (Peace be upon Him): "The Believer is a brother to each believer at all times. He shall protect his brother, defend him in his absence and care for him".<sup>3</sup>

« المؤمن أخو المؤمن من حيث لقيه، يكف عليه ضيعته، ويحفظه من ورائه، ويحوطه. »

<sup>1</sup> Sixth Medical Islamic Jurisprudence Symposium on AIDS-related social problems from an Islamic perspective, Kuwait, 6-8 December 1993.

<sup>2</sup> Narrated in Muslim, Abou Dawood, Ibn Maja, Al Termizi and Ibn Hanbal by Abou Horeira

<sup>3</sup> Narrated in Al Bukhari, Muslim, Abou Dawood, Al Termizi and Ibn Hanbal by Ibn Omer



Therefore, and in the light of the aforesaid statements, the AIDS patient should be dealt with like any other patient, with regard to his treatments, relief of his distress, caring for him, protecting him, helping him through his ordeal and retaining his secret. God alone can bring him to account.

It is impermissible to defame, stigmatize or scorn an AIDS patient. God the Almighty says: "Do not defame one another" «ولا تلمزوا أنفسكم» [Al Hujurat: 49; verse 11]. The Prophet (Peace be upon Him) said: "It is enough of all evil for someone to scorn his Muslim brother".<sup>1</sup>

«بحسب امرئ من الشر أن يحقر أخاه المسلم».

Hence, all doctors and other health workers should extend to AIDS patients all the care they need, in the same way that they would extend care to other patients".

One of the main recommendations of the symposium was the following:

HIV/AIDS patients are entitled to receive treatment and health care, as their health status may require, irrespective of how they have contracted the infection. The patient, on the other hand, should inform his/her doctor, in order to help protect the doctor and other patients from the risk of infection. At the same time, the doctor should continue to treat the patient, while taking all possible precautionary and preventive measures with regard to himself and others. The infected person should also be taught how to keep his condition from further deterioration and prevent the transmission of the infection. Under no circumstance should the patient be persecuted, abandoned or stigmatized on account of his/her illness.

## 2.6 Drug promotion

It is generally accepted that the pattern of drug use in a particular community is largely affected by the type of information provided by medical representatives of drug industry. The influence of this kind of practice may be reflected in the widely recognized irrational prescription of drugs by physicians and irrational dispensing of drugs by pharmacists. This fact has been recognized by the medical profession in several documents published to regulate the practice of medical drug promotion. At global level, the International Federation of Pharmaceutical Manufacturers Associations (IFPMA) has published a code of ethics to regulate drug promotion activities of its drug industry members.

At the Thirty-ninth World Health Assembly in May 1986, in resolution WHA39.27, the Member States of WHO endorsed the global document on Ethical Criteria for Medical Drug Promotion. The resolution urged Member States to:

- 1) Take account of these ethical criteria in developing their own appropriate measures to ensure that medicinal drug promotion supports the aim of improving health care through the rational use of drugs;
- 2) Monitor and enforce, where appropriate, the implementation of the measures they have developed.

<sup>1</sup> Narrated in Muslim, Abou Dawood, Al Termizi, Ibn Maja and Ibn Hanbal, by Abou Horeira

In this respect, WHO's Regional Office for the Eastern Mediterranean is collaborating with Member States to develop national legislation that regulates the activities of medical representatives and at the same time encourages professional associations for pharmacy professionals, health personnel, consumer groups and the mass media to:

Use the criteria as appropriate to their spheres of competence, activity and responsibility; and,

Adopt measures based on these criteria as appropriate, and monitor and enforce their standards.

This document was further revised as per the resolution of the Forty-seventh World Health Assembly, WHA47.16 (May 1994).

## **2.7 Economic aspects of medical ethics**

As patients are probably the only consumers who have to seek permission from someone else in order to obtain services, medical ethics related to medical practice play an important economic role.

Physicians are therefore the main decision-makers in health and medical expenditures. Excessive prescription by physicians and reliance on the fees-for-services mode of reimbursement are referred to as main causes of cost escalation in several health care systems. In many countries, patients consider insurance policies as open accounts. The result has been that physicians and other health care providers have acted accordingly and the cost of health care has soared.

Providers of health services may join together to form health maintenance organizations (HMOs), as is happening in the U.S.A. It is found that the professional ethic is a powerful motivator to provide the best care, even when it goes against the economic interests of the organizations. But when, in many cases, HMOs are established or purchased by insurance companies, physicians themselves fall under the control of entities that have not taken the Hippocratic oath. These entities may find that the price of stock and the profit incentive may be more important than the welfare of patients. In some cases, owners of private business (such as hospitals, HMOs, insurance companies) may exert economic pressures on their physicians, leading to ethical dilemmas. One of the sensitive key issues in this respect is the use of scarce resources in health care. Indeed, equal access to medical care, irrespective of financial and economic status, was an important factor behind the development of bio-ethics. Many would say that the seminal event in the modern era in this respect was the publication on 9 November 1962 of an article in *Life* magazine, entitled "They decide who lives, who dies". This article was prompted by the setting up of a committee in the city of Seattle, USA, to examine which of a number of patients should have access to the newly discovered and life-saving technology of kidney dialysis. In 1992, this same city hosted 40 leading figures in the field for a conference on the "Birth of bio-ethics".

In many least developing countries, unfavourable economic conditions have led to the deterioration of health status. Some observers have stated that the actual health situation in Africa is worse than that of a decade ago. Economists think that justice and equity in resource allocation and distribution in health systems are the greatest medical ethical needs in these countries.

### **3. RECENT DEVELOPMENTS RELATED TO BIO-ETHICS**

#### **3.1 Role of the United Nations Educational, Scientific and Cultural Organization**

Medical ethics should deal with new technologies and developments in sciences as well as with professional practitioners. As a topic of enquiry, bio-ethics has attracted many institutions and organizations.

Interest in bio-ethics was expressed at UNESCO from the seventies onwards, with the beginning of genetic engineering. In 1970, a symposium on the topic was organized in Madrid by UNESCO in conjunction with the Spanish Higher Council of Scientific Research.

Since that date, UNESCO has taken an increasing number of initiatives in this field:

Organizing symposia

Drafting recommendations

Publishing (for example, *Biology and ethics* by Bruno Ribers in 1978; in 1991, texts of the communications and discussions on bio-ethics and cultures; in 1991, the discussions of the meeting organized in Moscow on bio-ethics and human rights; and the publication in 1993 of a work by Eugene B. Brody on *Biomedical technology and human rights*; etc.)

Drafting thematic reports (for example, the research work carried out under the aegis of the World Federation for Mental Health).

The driving force of UNESCO work was the International Bio-ethics Committee, the first institution of its type to be set up in the world. The setting up of the Committee was preceded by a period of preparatory groundwork carried out by a Scientific and Technical Orientation Group. The group adopted a pragmatic working method to the study of a specific theme from among the following:

- Genome research
- Embryology
- The neurosciences
- Gene therapy
- Genetic testing.

#### **3.2 Role of CIOMS**

The Council for International Organizations of Medical Sciences (CIOMS) has contributed, since its creation, to the development of bio-ethics. An international dialogue on health policy, ethics and human values was initiated during the decade 1984-1994. CIOMS cooperated closely with WHO, UNESCO and other agencies and institutions concerned by bio-ethics. CIOMS held its XXVIII conference on "Poverty, vulnerability, the value of human life and the emergence of bio-ethics" in Mexico, in April 1994. The 110 participants reached broad agreement on a number of issues and agreed to conclude their deliberation by issuing a declaration setting up a global agenda for bio-ethics. The declaration recalled the principles of bio-ethics, which entail concrete obligations on the part of international agencies, governments, health care providers, professional associations and societies at large as well as individuals and specific groups of the population. It stressed that efforts should

also be made to promote and strengthen the continuing development of national and international capacities for ethical analysis of current and emerging changes in health care affecting individuals and populations. A North-South dialogue in this respect was encouraged. Since bio-ethics has developed primarily, but not exclusively, in the most developed countries, there is a pressing need for the elucidation and universal adoption of basic bio-ethical principles, in a manner that acknowledges the world's diverse moral and cultural perspectives, priorities and values. CIOMS has made substantial and substantive contributions to bio-ethics, particularly through the "International dialogue on health policy, ethics and human values" during its first decade (1984-1994). WHO is continuing its partnership in this Dialogue.

### **3.3 Role of IOMS**

The Islamic Organization for Medical Sciences (IOMS) has organized international conferences on Islamic medicine and held a large number of specialized seminars addressing all aspects of Islamic medicine, including Islamic views on recent technological developments and medical practices. Conferences of the Islamic Organization of Medical Sciences bring together scientists from various specialized disciplines and religious scholars to discuss these issues from various aspects.

During the first International Conference on Islamic Medicine held in Kuwait, in January 1981, a code for Islamic medical ethics was adopted. The code covers the following topics:

- Definition of medical profession
- Characters of the physicians
- Doctor-doctor relationship
- Doctor-patient relationship
- Professional secrecy
- Doctor's role during war
- Responsibility and liability
- The sanctity of human life
- Doctor and society
- The doctor and modern biomedicine
- Medical education
- The oath of the doctor.

## **4. PROMOTION OF BIO-ETHICS IN THE EASTERN MEDITERRANEAN REGION**

Biomedical ethics should be developed and should evolve according to the many different societies, cultures and levels of growth. Developing countries should pay more attention to the issue of ethics in the health system and develop appropriate mechanisms to protect ethical concerns.

For the Eastern Mediterranean Region, a threefold approach to develop biomedical ethics could be based on:

- Training of health and health-related professionals
- Institutional development and capacity building
- Promotion of codes of ethics.

#### **4.1 Training**

As recommended by WHO, training in medical ethics and codes of conduct should be offered by all schools of medicine and allied sciences. Health-related institutions and professionals should also be exposed to the principles of biomedical ethics.

Such training should emphasize local and regional cultural and religious norms and should aim at developing a critical mass of national and regional ethicists.

##### **The teaching of medical ethics**

WHO organized a consultation with leading medical practitioners, in Geneva, from 12 to 14 October 1994, on the teaching of medical ethics.

The participants in the Consultation agreed that the major objective of teaching medical ethics is to ensure that the physician is sensitive to ethical issues in all his or her professional decisions. In addition, there was consensus that medical ethics should be an integral part of medical education and that the teaching of medical ethics should be obligatory in all medical schools throughout the continuum of undergraduate, postgraduate and continuing education levels. When developing curriculum content, it is important to bear in mind that health care is provided increasingly by teams of health professionals. The participants strongly endorsed the principle that the teaching of medical ethics should be interactive using seminars, problem-based learning and case-studies. It was agreed that WHO and national medical associations will continue to coordinate efforts in advocating the importance of teaching medical ethics at all levels.

The meeting was unanimous in stating that ethics should be an obligatory course and not an elective. Within the framework of the above factors, the participants agreed that all medical undergraduates should be exposed to a core course on medical ethics (see Annex).

#### **4.2 Institutional development and capacity-building in biomedical ethics**

Every country should have a dynamic mechanism for dealing with ethical problems as well as for regulating ethical norms in medical practice and research.

This may involve the establishment of a national medical ethics commission and local and institutional ethical committees. The composition of national medical ethics commissions should ensure representation of all concerned parties, including professional societies, associations and unions. The national commission should be entrusted to formulate policies related to biomedical ethics and to set norms and standards for health and medical interventions and should also be consulted in case of research proposals. Such commissions should be independent from all forms of pressure.

Ethical guidelines developed globally or regionally should be periodically reviewed and enriched by national committees and societies, bearing in mind that ethical principles should be more like statutes and constitutions — difficult to change.

#### **4.3 Promotion of codes of ethics**

WHO, in collaboration with Ministries of Health, should advocate the need to develop biomedical ethics and should strive to promote an ethical culture in health systems. Indeed, WHO has always played a catalytic role in developing ethical guidelines, in updating them and in disseminating all materials related to biomedical ethics.

## **Annex**

### **MEDICAL UNDERGRADUATE COURSE ON MEDICAL ETHICS**

#### **Principles**

Ethical principles in practice  
Human rights and medicine  
Professional code of conduct  
The professional-patient relationship: information, consent, autonomy, privacy, decision-making for incompetent patients or in cases of emergency, professional standards, humanization of health care  
Ethical issues regarding the commercialization of medical practice  
Ethical issues in preventive and promotive medicine

#### **Children and young people**

Rights of children and young people in medicine  
Ethical issues related to autonomy and competence  
Ethical issues related to consent  
Ethical issues related to confidentiality  
Ethical issues related to research on children

#### **Reproductive and genetic technology**

Ethical issues in reproductive medicine  
Ethical issues in contraception  
Ethical issues related to abortion  
Ethical issues related to sterilization  
Ethical issues related to assisted reproduction  
Ethical issues related to surrogacy  
Ethical issues related to embryo research

#### **Care for the dying**

Ethical issues in intensive and terminal care  
Ethical issues related to cessation of treatment  
Ethical issues related to non-resuscitation  
Ethical issues related to assisted suicide and euthanasia

#### **Research**

Medical research and ethics  
Ethical issues in transplantation

**Doctors with dual obligations**

Ethical issues in occupational health  
Ethical issues related to medical reports for insurance; police and prison doctors;  
doctors with business interests  
Ethical issues related to providing expert testimony for court cases

**Relations between doctors**

Ethical issues regarding advertising  
Ethical issues with regard to international cooperation in the field of health care  
Ethical issues related to referrals  
Ethical issues related to reporting impaired colleagues

**Inter-professional relations**

Ethical issues regarding the use of alternative medicine  
Ethical issues related to liaison with social workers/pharmacists/other health  
professionals

**Rationing and allocation of scarce resources**

Ethical issues in health administration  
Ethical issues in health economics and resource allocation  
Ethical issues in the allocation of scarce resources